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The study analyzed and documented how the Department of Defense (DoD) Region III Health Services Plan was developed at Dwight David Eisenhower Army Medical Center focusing on the process undertaken. The Region III Plan is rooted in the managed care principles adopted under the DoD's prior Coordinated Care Program. Developed in coordination with the Services' Surgeons General, the DoD Managed Care Program is principally designed to provide medical treatment facility commanders the authority, tools, and flexibility needed to better perform their health care missions.

The author interviewed several key personnel involved in the health plans development and actively involved himself in Lead Agent meetings. The interviews revealed that each of the key personnel remained consistent in their philosophical direction concerning what the regional plan should look like. The key lessons learned were that other Lead Agents should start their developmental efforts early, their health plans should be localized or tailored to fit the medical environment, and the process of writing the health plan is a difficult one.

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CASE STUDY:

THE DEVELOPMENT OF A TRI-SERVICE REGIONAL HEALTH SERVICES PLAN AT DWIGHT DAVID EISENHOWER ARMY MEDICAL CENTER

A GRADUATE MANAGEMENT PROJECT

SUBMITTED TO THE FACULTY OF

BAYLOR UNIVERSITY

IN PARTIAL FULFILLMENT OF THE

REQUIREMENTS FOR THE DEGREE

OF

MASTER OF HEALTH ADMINISTRATION

BY

CAPTAIN PETER C. DANCY, JR., MS, USA

FORT GORDON, GEORGIA

AUGUST 1, 1994

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ABSTRACT

The study analyzed and documented how the DoD Region III Health Services Plan was developed at Dwight David Eisenhower Army Medical Center focusing on the process undertaken. The Region III Plan is rooted in the managed care principles adopted under the DoD's prior Coordinated Care Program. Developed in coordination with the Services' Surgeons General, the DoD Managed Care Program is principally designed to provide medical treatment facility commanders the authority, tools, and flexibility needed to better perform their health care missions.

The author interviewed several key personnel involved in the health plans development and actively involved himself in Lead Agent meetings at Eisenhower Army Medical Center and other regional locations. The interviews revealed that each of the key personnel remained consistent in their philosophical direction concerning what the regional plan should look like, namely that it should give hospital commanders maximum flexibility in designing their plans.

Based on this research, the author prepared lessons learned concerning Region III's development of the Health Services Plan to be used by other Lead Agents who will undergo this process. The key lessons learned were that other Lead Agents should start their developmental efforts early, their health plans should be localized or tailored to fit the medical environment, and the process of writing the health plan is a difficult one.

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Introduction

Background Information

The American Health Security Act, the health care initiative endorsed by the President, will enable the Department of Defense (DoD) to define military medical benefits to ensure consistency throughout the United States (U.S.). Eisenhower Army Medical Center (EAMC) is playing a leadership role in this effort.

As a result of this initiative, the DoD divided the Military Health Services System (MHSS) in the Continental United States into 12 regions (Figure 1). The military services' medical treatment facilities (MTFs) in the U.S. have been grouped into a region. Each of these regions has a military Medical Center Commander serving as Lead Agent with overall responsibility for coordinating and integrating health services in a given DoD Health Services Region (DA OTSG, May 1994). EAMC has been designated as the Lead Agent for DoD Region III, the region which encompasses Georgia, South Carolina, and most of Florida (Figure 2). EAMC is the first U.S. Army medical center to plan and develop the DoD Lead Agency health care delivery and Tri-service regional health services plans for the military beneficiaries of the MHSS.

The DoD regionalization plan aligns the MHSS with the

principles of increased efficiency and effectiveness, tenets central to national health care reform objectives. In addition, EAMC must develop an integrated health care plan for the Health Service Region (HSR). The estimated Region III beneficiary population of 1.13 million is second in size only to that of the National Capital Region (Table 1). The target date for development of the health services plan is prior to 1 April 1994, with implementation of the plan slated for November 1995 (DoD OASD (HA), Nov 1993).

Table 1[1]. - Regional Lead Agents and Supported Populations

REGION	POPULATION	LEAD AGENT	ARMY MTFs	NAVY MTFs	AIR FORCE MTFs	TOTAL
1	1,161,604	TRISERVE	7	4	5	16
2	867,083	Portsmouth	3	3	2	8
3	1,132,418	Eisenhower	4	4	6	14
4	503,632	Keesler	3	2	5	10
5	699,354	Wright Patterson	3	1	3	7
6	1,031,513	Wilford Hall	4	1	12	17
7	338,907	William Beaumont	2	0	6	8
8	738,539	Fitzsimmons	5	0	11	16
9	818,692	San Diego	1	4	5	10
10	439,934	David Grant	1	2	1	4
11	355,065	Madigan	1	2	1	4
12	164,334	Tripler	1	0	0	1
TOTAL	**8,251,075**		**35**	**23**	**60**	**118**

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[1] Reprinted from the Assistant Secretary of Defense memorandum entitles "Regionalization of the Lead Agent Concept", dated July 24, 1993.

Population numbers are estimates based on FY 91 DMIS data

Conditions Which Prompted the Study

Historical Perspective

The health care system in the United States has generated a tremendous amount of national attention over the past several years. There has been increasing emphasis on controlling and reducing the cost of government medical programs, as well as reducing defense spending. The establishment of the White House Health Care Reform Task Force demonstrated the Administration's commitment to designing a system of health care that ensures universal access, controls the rising costs of health care, and ensures quality care.

This scenario presented the Department of Defense with a unique challenge, that of strengthening the performance of the MHSS by ensuring that access is made available to our beneficiaries within our own health care system. In response to this challenge and in concert with the White House Health Reform Task Force, on October 1, 1993 the Department of Defense embarked on a new initiative in DoD managed care. Rooted in the managed care principles adopted under the DoD's prior Coordinated Care Program, this initiative, entitled the Managed Care Program (MCP), has resulted in the regionalization of the MHSS and the designation of Lead Agents (DoD OASD (HA), Aug 1993).

Lead Agent Concept

Brigadier General (BG) Vernon Spaulding, the Commander of EAMC and the Region III Lead Agent, has been charged with coordinating the development of the Region III health services

plan. The plan must be developed in concert with input from the military treatment facility commanders (Army, Navy, and Air Force) in the region.

The previous business orientation to providing military health care centered around catchment areas, i.e., 40-mile radius of the military treatment facility. This philosophy changes under the Lead Agent concept because provisions must be made for all military beneficiaries, minimizing differences in access, quality, benefits, and costs (DA EAMC, 1993).

The regional health services plan must address several issues, one of which is access. Beneficiaries who live outside of the military hospital service areas (catchment areas) may be able to use the contractor if the contractor decides to set-up TRICARE Prime and Extra, options available under the triple option. In catchment areas and other areas DoD specifically designates, the contractor must implement the triple option. A Request for Proposal (RFP), developed in conjunction with the health services plan, will be the document that tells the contractor which services he is to contract for within the civilian community. This "wrap-around" contract is intended to secure a network of civilian providers to complement the military system (Tomich, 1993). EAMC is aware of several organizations interested in the Region III contract, namely Blue Cross of Georgia, Prudential, AETNA, Humana, and Columbia Healthcare Systems. According to Colonel (COL) Henry Beumler, chief of the Coordinated Care Division at United States Army Health Services

Command (HSC), the drafters of these health care plans must be "active, aggressive players," ensuring that the contract does what we want (Harben, 1993).

EAMC's development of the Region III health services plan is extremely timely. This multi-service process offers the author an excellent opportunity to observe and analyze a contemporary event previously inaccessible to investigation. It will allow the author to provide an unbiased retrospective assessment of the events that took place in preparation of the plan, and offer lessons learned to other DoD Lead Agents who will undergo this process subsequent to EAMC.

Problem Question

How is the regional health services plan for DoD Region III being developed and what will be the plan for delivering health care in DoD Region III?

Working Literature Review

Military Regionalization in Its Infancy

The regionalization of military health service support is not a new concept. As early as 1957, the United States Army established a limited form of military medical regionalization in Europe and it was generally regarded as a success. The Medical Department Activity (MEDDAC), an even more limited form of regionalization, was started by the Army in the continental United States (CONUS) in 1969. The Air Force and Navy have had a limited form of medical regionalization since 1969 and 1971, respectively (DA, 1972).

The impetus for the military regionalization concept during the 1960's stemmed from some of the same health care challenges that this country's military faces in 1994: the shortage of health care resources; the rapidly escalating costs of care, duplication of services and facilities; and, the waste of scarce resources. As a result of these inefficiencies in the system, two laws were enacted in 1965 and 1966 that spurred the regionalization movement - the Regional Medical Program Amendments to the Public Health Service Act (P.L. 89-239) and the Comprehensive Health Planning Act (P.L. 89-749) (DA, 1972).

In the early 1970's, it was recognized by the senior DOD leadership that there was a strong possibility that the drafting of professional medical personnel could cease after June 30, 1973 and this action could potentially jeopardize the availability of care that active duty soldiers and other beneficiaries were accustomed to. As a result, the Army Chief of Staff, General Westmoreland, directed The Surgeon General of the Army and his subordinate commanders to devise courses of action designed to reduce demand and increase productivity in preparation for this event. Courses of action ranged from screening applicants for Physician Assistant training to considering raising dental standards for recruits (DA Chief of Staff, 1972).

In 1972, as the military moved to initiate an all-volunteer force, the Secretary of Defense directed the implementation of a Tri-service Regionalization Concept. Regionalization, as defined in the DoD Concept during that era, was essentially a management

system designed to improve all aspects of health services through the mutual cooperation and coordination of military peacetime health care institutions (DA Office of the Adjutant General, 1972). The objective of this test concept was to determine the ability of the military to: increase the efficiency and economy of military medical services operations; efficiently use physicians, dentists, and other health care personnel; and improve the quality of patient care.

Effective July 1, 1972, this Tri-service Regionalization Concept called for the division of the United States, Japan, and Europe into 14 Military Medical Regions for peacetime military health care purposes. Each Military Medical Region was further subdivided into an Army, Navy, and Air Force Subregion (DA OTSG, 1972). The concept was tested in three regions - the Tidewater Military Medical Region (Navy Subregion), the Gulf Military Medical Region (Air Force Subregion), and the Southeast Military Medical Region (Army Subregion).

The Southeast Military Medical Region included all military treatment facilities in South Carolina, Georgia, Alabama, and Florida. As testing of the concept progressed, the Southeast Region acquired the state of Mississippi increasing from 58 to 62 the number of military health care facilities in the region. The Commanding Officer, U.S Army Hospital, Fort Gordon, Georgia, was designated as the Regional Coordinator. As with the current EAMC commander being charged with maximizing the use of all direct care assets in Region III, the Fort Gordon hospital commander

during that era was also responsible for the efficient use of allocated medical resources among the services.

During the planning stages of this Tri-service Regionalization Concept, several potential disadvantages to its implementation were identified, namely: objection by some military commanders in anticipation of a reduction in their degree of control over their resources decisions. Some senior medical leaders may have viewed the initiative as the first step towards a unified medical service (DA, 1972). However, feedback from the field after implementation revealed that the regionalization concept was "enthusiastically endorsed" as a means to more economically provide better services to the beneficiaries, but, its success was dependent on active and continuous support at all levels (DA Army Hospital, 1972; DA Army Hospital, 1973).

Due to these favorable results, the Assistant Secretary of Defense (Health & Environment) approved the implementation of the regionalization concept within the 13 CONUS regions on October 1, 1973. Deemed the Armed Forces Regional Health Services System, the objectives of the system were to:

1) Improve interservice health planning and delivery of health services.

2) Improve the delivery of health services to all active duty personnel and other eligible beneficiaries.

3) Assure the existing command relationships do not interfere with the delivery of comprehensive health services.

4) Provide a cooperative management arrangement that will afford greater opportunities for clinical research and continuing education.

5) Eliminate or reduce health services and associated programs that the DoD workload cannot fully justify (Deputy Secretary of Defense, 1973).

A Tri-service Regional Review Committee was established for each region composed of a hospital commanding officer designated by each of the Surgeons General. The commanding officer at the U.S. Army Medical Center at Fort Gordon was selected to represent the Army military treatment facilities in the Southeastern Military Medical Region, Region 13. The commanding officers at the Naval Regional Medical Center, Jacksonville, Florida and the United States Air Force Regional Hospital, Shaw Air Force Base, South Carolina completed the Region 13 committee, with chairmanship rotating periodically.

To ensure that the objectives of regionalization were met, the Chairman of the Regional Review Committee was required to submit a quarterly report to the Military Medical Region Coordinating Office (MMRCO) at DA. The quarterly reports were designed to assess the improvements, quality, efficiency and economy of health services in each region (Deputy Secretary of Defense, 1973). This requirement continued until most recently when Lead Agents were designated in 1993.

The CONUS Armed Forces Regional Health Services System was intended to contribute to more effective management of scarce

resources. However, it was recognized by military leadership that 13 CONUS Military Medical Regions was not the optimum management arrangement. Therefore, in 1977 the Assistant Secretary of Defense (Health Affairs) directed the modification of boundaries resulting in 9 regions. Eisenhower Army Medical Center retained leadership of the Army contingent for DoD Region VII (Southern Military Medical Region) serving the regional military medical facilities in Tennessee, Mississippi, Alabama, Georgia, and Florida (Deputy Secretary of Defense, 1977).

In an effort to further decentralize control of the delivery of health care in the U.S. Army, Headquarters, HSC implemented a change in their relationship with Army military treatment facilities. In 1984, HSC implemented a policy designed to give MEDCEN Commanders greater operational control over MEDDAC Commander(s) in their region (Figure 3). This action stemmed from the difficulty Headquarters, HSC experienced in attempting to provide the desired degree of day-to-day supervision of health care delivery. EAMC assumed the role as the regional integrating center for the military treatment facilities in the southeast (Figure 4). The intent of this action was to place greater responsibility for supervising the delivery of medical care closer to the level where the care was provided (Department of the Army, HSC, 1984).

This expanded mission for the Eisenhower Health Service Region resulted in the appointment of 14 consultants in major specialties. The consultants' duties and responsibilities were

geared toward assisting MEDDAC Commanders and individual specialists in quality assurance, officer distribution, and health care deliver issues at the local level. The basic principles behind the concept remained virtually unchanged since their inception. However, the philosophy, structure, and operation of DoD regional military medicine changed with the adoption of the DoD Managed Care Program on October 1, 1993 (DoD OASD (HA), Aug 1993).

Managed Care Program (MCP) Overview

The concept of managed care in the civilian sector began to develop through the creation of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and health care insurers who began to manage more closely the payments they made for health services. Wolford et al. (1993) contend that the managed care initiative has evolved into a micromanaging of consumer choice and selection of providers. They further contend that the ideal or futuristic managed care delivery system will be an organized body of health services and financial mechanisms whose function it is to manage and provide the right medical services at the right place and time. In addition, there would be mechanisms in place to assure community accountability and responsibility (Wolford et al., 1993).

The DoD Managed Care Program was developed in coordination with the Services' Surgeons General and is principally designed to provide MTF commanders the authority, tools, and flexibility needed to better perform their health care/medical mission (DoD

OASD (HA), Aug 1993). The medical mission of the DoD, as expressed by the Deputy Secretary of Defense, is twofold, namely "provide, and to maintain readiness to provide, medical services and support to the armed forces during military operations" and, "provide medical services and support to members of the armed forces, their dependents, and others entitled to DoD medical care" (DoD OASD (HA), Aug 1993).

Initiated on October 1, 1993, the centerpiece of the MCP is the 12 Health Service Regions. The regions were established to ensure an adequate beneficiary base to support cost-effective volumes of care under the impending MCS contracts. In addition, beneficiaries would be afforded regional access to tertiary care from military MTFs.

The design and implementation of the MCP has been guided by the following principles: 1) Serve beneficiaries to provide a combat-ready force, 2) Have local accountability with centralized direction and monitoring, both functions of the lead agents and MTF commanders, 3) Decentralized execution, 4) Achieve greater equity in terms of access, quality, cost, and benefits, 5) Be flexible and easily administered, 6) Optimize the use of MHSS resources, such as MTF primary care managers, and 7) Be consistent with the national health care reform efforts, i.e., use manage care principles (DoD OASD (HA), Aug 1993).

Lead Agent Responsibilities

Each of the DoD Health Service Regional Lead Agents has a number of responsibilities. In addition to developing the

regional health services plan (in coordination with regional MTF commanders), each is responsible for the following actions:

1) Develop a plan for the delivery of care and service.

2) Develop regional policies for and coordinating patient referrals or non-availability statements.

3) Coordinate the development of regional capitalization maintenance and repair/renovation plans.

4) Conduct ongoing evaluation of resource utilization and access through the Health Service Region.

5) Develop the regional contract requirements for the Health Service Region (DoD OASD (HA), Jul 1993).

In an effort to manage these responsibilities, Lead Agents should have the authority to manage CHAMPUS dollars, approve referrals, recommend designation of regional Specialized Treatment Services and require coordination of non-availability statements. Conversely, Lead Agents will not have the authority to make decisions about direct care funds or personnel actions within individual service hospitals. Each individual service (Army, Navy, Air Force) will retain this authority (DoD OASD (HA), Jul 1993).

Regional Health Services Plan Guidelines

The "Regional Lead Agent Health Services Planning Guidelines" (1993) provides some fairly definitive steps that regional Lead Agents can take in developing their regional plans. This document identifies 11 planning "elements" that should be addressed to ensure the smooth transition to regionalized health

care under the DoD Lead Agent concept. A brief synopsis of each is listed below:

1) Medical Readiness. Joint efforts in some contingency operations should be addressed; the plan should address areas of efficiencies that can be achieved with Military Support of Civil Authorities, the National Disaster Medical System, and the Department of Veterans Affairs - DoD Contingency System.

2) Resource Management. Lead Agents will manage CHAMPUS funds for the region; hospitals in the region will receive direct care and military personnel (MILPERS) funds directly; management of referrals from direct care to CHAMPUS will be critical to a regions financial success.

3) Information Systems. An effective information management system with a quick access, meaningful data base is key to managing regional health services.

4) Specialized Treatment Services (STS). Regional or national STSs will be established for certain high technology/high cost procedures, with the ultimate location of the STS approved by the OASD (HA).

5) Graduate Medical Education. In an effort to gain greater efficiencies in training physicians, nurses, and enlisted specialists, regional graduate medical education programs should be thoroughly reviewed in an effort to achieve economies of scale or the most efficient use of limited resources.

6) Enrollment/Registration. This involves having "real-time access" to information concerning the number of enrolled

beneficiaries that a facility is responsible for. Lack of this information could entail the development of an adequate interim information system or the contracting of a system.

7) Network Development. This involves a review of the demographics of the population to be served and a corresponding determination of the number/type of providers needed to support the population. A network refers to a group of providers who collectively provide health care services to a designated population.

8) Marketing/Education. This will involve marketing the health care plan to both beneficiaries and providers; as beneficiaries are enrolled and providers are empaneled, staff members must be educated on all aspects of the plan.

9) Quality Management Program/Utilization Management. The Managed Care Support (MCS) contracts will be subject to standard quality and review procedures outlined in DoD guidance. Effective planning in this area could result in a more cost effective delivery system and a healthier population served.

10) Health Promotion/Wellness. Community education and outreach programs must be established to achieve a primary goal of preventing beneficiaries from becoming ill. 11) Evaluation Plan. In an effort to guide outcomes monitoring, quality, access, and cost baseline measures must be established to effectively evaluate the success of the health care delivery plan.

Regional Health Service Plan Case Study

The "Case Study on the Development of Regional Health Service Plan" (1993) was designed to be used in conjunction with the OASD (HA) Planning Guidelines. This document covers such areas as: the regional health care environmental assessment; the plans development (to include the 11 planning areas identified in the previous section); and data sources to obtain needed information and statistics on critical areas of interest, i.e., demographics, utilization review, and provider sources.

This document was not prepared as a "blue-print" for a health care plans develop. Rather, the intent was to provide an example of an approach that can be adopted by a Lead Agent in the developmental process (DoD OASD (HA), Nov 1993).

Propositions

The propositions that will be addressed during this study are as follows:

1) EAMC will use the case study on the development of a regional health service plan as a baseline for the Region III plan.

2) The regional MTF Business Plans will be used to assist in the development of the Region III health services plan.

3) A comprehensive health care environmental assessment, to include historical, forecasted, and benchmark information, will be undertaken to provide an objective basis for determining regional requirements.

4) The information gathered in the regional environmental

assessment will be integrated into the 11 planning areas defined by the Office of the Assistant Secretary of Defense (Health Affairs).

Purpose

The purpose of this case study is to observe, analyze, and document how the DoD Region III Health Services Plan is developed. The chronology of events that lead to the final product (health care plan) can provide valuable historical documentation of the decision processes that went into the plan. The objective is to provide a coherent statement of how the plan was developed and include in my completed project the actual DoD Region III health care delivery plan.

The unit of analysis for this case study is the development of the DoD Region III health services plan.

Methods and Procedures

This Graduate Management Project is a study where the author used the skills acquired during the didactic phase of the U.S. Army-Baylor University Graduate Program in Health Administration to observe, analyze by case study, and catalog the development of the health services plan for Region III. The author produced a document that retrospectively looked at the approach adopted by EAMC to develop the plan and determine how the final product integrates with national health care reform initiatives. The following objectives were accomplished during this study:

The author conducted a literature review using the medical

library of EAMC, archival records in the EAMC Headquarters, and resources at the Medical College of Georgia. The author also researched previous and current policies on regionalization of military health care. The purpose of this review was to determine current and developing trends in U.S. military health care regionalization.

The author interviewed several key personnel who were involved in the development of the Region III Health Services Plan, namely: the Commander, EAMC and DoD Region III; the Deputy Commander for Administration (DCA)/Chief of Staff, EAMC; the Region III Lead Agent Project Officer; and the Executive Officer, Region III Lead Agent Project Office. Emphasis during the interviews was cataloging their roles in the development of the plan. In addition, other representatives from the Region III and Region IV Lead Agent Offices were questioned.

In an effort to provide a common thread among each of the key personnel interviewed, a standardized open-ended interview process was used following the guidance provided in Patton (1990). This format was used to facilitate gathering the same information from each person interviewed. In addition, this systematic method made data analysis easier. The following questions were asked of each:

1. What do you see as the major missions, functions, and responsibilities of the Lead Agent, particularly in this region?

2. How is the Lead Agent concept expected to integrate with President Clinton's Health Care Reform initiatives?

3. How were you involved in the health care delivery plans development?

4. What do you see as the key components of the health care delivery plan?

5. What do you think were some of the lessons learned as you developed the health care plan for this region?

6. What impact do you think the visit to Keesler Air Force Base will have on our initiatives in this region?

Some of the key personnel were asked additional questions based on their areas of responsibility. Complete narratives of the responses from each of the key personnel are included in the appendices.

In addition to interviewing the Commander of EAMC to determine his role in developing the health services plan, as previously stated, he was interviewed to determine his perspective on how the health services plan should integrate with the President's Health Plan.

The author reviewed and analyzed a document prepared by Health Affairs entitled "A Case Study on the Development of Regional Health Services Plans" dated November 30, 1993. The review allowed the author to determine to what extent the guidance provided was used in the development of the regional health services plan.

The author was actively involved in Lead Agent meetings here at EAMC and when possible, other regional locations, to remain abreast of the current issues regarding plan development. These

meetings varied in detail and scope. They ranged from sitting in on video and audio teleconferences with Health Affairs, the Surgeons General and their staff as they discussed the "strategic" direction for the health services plan, to observing the Region III Lead Agent staff apply the strategic guidance, to attending a meeting at Keesler Air Force Base with the Commanders of Region III and IV as they discussed their health services plan differences and similarities. In addition, the author documented the major topics discussed, significant debates on critical issues, and key decisions made during these meetings.

The author used interviews, archival records, and direct observations to prepare lessons learned concerning Region III's development of the health services plan. These lessons learned were compiled for use by other Lead Agents to benefit from EAMC's experience.

Study Design

The author used a qualitative study design to research how EAMC developed the Region III health services plan. The study included data discovered before and during the authors' involvement in the health plans developmental processes and concluded once the plan was completed. The two primary references the author used in this study design were Yin's (1989) book on case study research and Patton's (1990) book on qualitative research methods. These references aided in the development of the study design, data collection efforts, and in determining the validity and reliability of the GMP.

Validity and Reliability

In Yin's (1989) book on case study research, he recommends the use of several techniques to enhance construct validity and reliability. To enhance construct validity, Yin recommends the use of at least one of the following techniques: multiple sources of evidence, establish chain of evidence, and have the draft case study reviewed by key informants. During this case study the author used two of the techniques. The case study report was reviewed by key participants and informants such as the Deputy Commander for Administration and the Lead Agent Project Officer. This process provided valuable feedback and recommendations on how this GMP could be improved prior to final submission.

The data collected for this case study came from multiple sources of evidence such as documentation, interviews, and direct observations. Each of the interviews with the key players in the plan's development was tape recorded.

The author established and maintained a case study data base to insure reliability. This consisted of case study notes, case study documents, narratives, tabular materials, and any other forms of information generated as a result of this study.

Ethical Issues

The ethical rights of the people interviewed during this study were strictly preserved. The author informed each person interviewed of the purpose of this study and that they had the right to refuse to answer any questions asked. In addition, all privileged information provided to the author was considered

confidential and was not released in this GMP.

Results

The Literature Review

The literature review was conducted at various institutions throughout this local area and yielded a fair amount of information on the regionalization of military medical services. The bulk of historical data obtained by the author pertaining to the "birth" of military regionalization was found here at EAMC. EAMC has been a "hub" for regional military medical activities for over 20 years, and fortunately, some of the official correspondence to, from, and through this institution still existed.

The author's proximity to the Region III Lead Agent Office was invaluable. Current information concerning the regional plans development was readily available during this dynamic and fluid process. A key point the author discovered, not surprisingly, was that the overall objective of military medical regionalization has remained virtually unchanged over the years, namely to increase the efficiency and economy of military medical service operations.

The Interview Process

Interviews with the key personnel involved in the development of the Region III Health Services Plan provided a critical dimension to the author's understanding of the process. These individuals were extremely knowledgeable about their roles and

the requirements stipulated by DoD Health Affairs and other organizations. The interviews with these personnel took place between the months of March and June 1994. Therefore, the responses given by the key personnel reflect the progressive nature of the Health Plans' development. As previously stated, a standardized open-ended interview process was used.

BG Spaulding's responses reflected the strategic or visionary role he played in developing the Health Services Plan (Appendices B and C). As he stated, he initially set the "atmosphere" for the plans development by visiting each of the MTFs in the region in an effort to break down barriers that may have existed between the three services. He relied on Colonel Stephen Xenakis and his staff to accomplish the day-to-day process of developing the plan.

The author's interview with Colonel Earl Mally, the DCA/Chief of Staff, revealed that he was "essentially an integrator of ideas, of people, of resources..." for the Region III Plan (Appendix D). His efforts focused on relationship building between EAMC and the regional MTFs. In addition, he ensured that the proper resources were in place to effectively execute the developmental process.

The interview with Colonel Stephen Xenakis, the Lead Agent Project Officer, occurred late in the Health Services Plans' development (Appendix E). Working directly for BG Spaulding, he clearly brought a wealth of knowledge and experience to the position. He was the architect of the process to develop the

health plan and was responsible for guiding the MTF Commanders in the development of their local plans.

The interview with Captain Robert Goodman, the Executive Officer of the Lead Agent Office, provided the author with the "nuts and bolts" of the developmental process (Appendix F). It was clearly the most revealing interview, one that provided a historical perspective of the day-to-day operations. From the author's viewpoint, Captain Goodman was the executioner of Colonel Xenakis' "architectural" work, responsible for the worker-bee functions for the Lead Agent Office. He worked very closely with other members of the Lead Agent staff ensuring that the directional guidance provided by Colonel Xenakis, among others, was fulfilled correctly and on schedule.

In terms of the major missions, functions, and responsibilities of the Lead Agent, the responses of each of the key personnel varied. BG Spaulding felt that the main responsibility of the Lead Agent is that of an organizer of the care for Region III. Colonel Mally responded by stating that the responsibilities of a Lead Agent represents a "framework ... to enhance cooperation among all DoD facilities within the region to provide care to eligible beneficiaries." As with BG Spaulding, he also spoke of the Lead Agent role being that of a coordinator between the DoD and Managed Care Support Contractor.

Colonel Xenakis succinctly stated that the mission of the Lead Agent is to write the regional plan, the statement-of-work for the Request-for-Proposal, and then go through the process of

announcing, bidding, awarding, and finally implementing the contract. Captain Goodman's response paralleled that of Colonel Xenakis, however, he provided a more "nuts and bolts" glimpse of what did occur in the Lead Agent's developmental process. Specifically, he stated that the initial responsibility of the Lead Agent was to contact each of the military hospitals in the region and assess their needs and capabilities. From there, the Lead Agent can begin to formulate how the regional health plan will be developed. Captain Goodman went on to state that the Lead Agent is supposed to garner support for the regional efforts, both in the region (i.e., MTF Commander support) and outside the region (i.e., Surgeons General).

BG Spaulding was one of two members of the Army Medical Department invited to join Mrs. Clinton's task force to work on totally reorganizing and establishing a national health care system. Therefore, BG Spaulding and the other key personnel were asked their thoughts on how the health services plan should integrate with the President's Health Plan (Appendix B). He stated that the major components of military medicine should reflect the health reform initiatives sought by the President. In addition, the military beneficiaries under the Lead Agent concept should be afforded a choice concerning the type of health plan they desire (e.g., HMO, PPO), which is a similar initiative under the President's proposed plan.

Colonel Mally's response reflected a similar thought process. He stated that the initiatives before Congress are "mirrored in

the TRICARE program", namely that employees be provided certain health care benefits from their employer and that there be a managed care component in how the DoD delivers health care (e.g., HMO, PPO). He further stated that the incentive for providers to keep people healthy has certain potential benefits: reduced health care costs, improved health status of population served, reduced requirement for medical care. Colonel Mally went on to state that the essence of the President's health care proposal embodied in the TRICARE concept is the Lead Agent's requirement to provide an accountable health plan to our beneficiaries.

Colonel Xenakis stated that the Lead Agent concept is the forerunner of what health reform should look like. It gives the White House a opportunity to shape health care reform by establishing a regionally based accountable health alliance across the country through the DoD. Captain Goodman stated that he is unsure how the Lead Agent concept will integrate with health care reform initiatives primarily because each of the services handles CHAMPUS funding differently. Because of this, he feels that integration will depend, in part, on how each Lead Agent views the importance of controlling this funding stream.

Not surprisingly, each of the key personnel played different roles in the development of the health care delivery plan. BG Spaulding stated that he was intimately involved in the plans development receiving briefings every two or three days as the regional plan began to be put on paper. He further stated that he was briefed by each of the MTF Commanders in the region at

their sites in an effort to gain an understanding of their unique challenges. Because of his requirements as Commander, the day-to-day work of developing the plan was accomplished by Colonel Xenakis and his staff.

As previously stated, Colonel Mally saw his role as that of an integrator of resources, people, and ideas. Colonel Xenakis took those resources, people, and ideas and devised a road map to complete the regional plan. Captain Goodman was the "foreman" who directed the "worker-bees" in the completion of the plan. He and the other members of the Lead Agent staff went on site visits to each of the MTFs in the region to meet the people who would be developing the local plans and to gain an understanding of their concerns.

The responses concerning the key components of the health plan varied. BG Spaulding stated that the key component or philosophy is that EAMC wants to "foster management of each of the MTFs in their own catchment areas." This philosophy is intended to allow MTF Commanders the ability to "call the shots" in terms of how the contractor will supplement the MTF. Conversely, Colonel Mally stated that the question of enrollment is the number one component. He stated that without enrollment, you lack the ability to adequately plan both the amount and cost of services to be rendered. In addition, he stated that the partnership relationship between the MTF Commander and the Managed Care Support Contractor is a component that is positive. Working collectively, they commanders and contractor have the

ability to deliver responsive, cost effective care to the beneficiaries served.

Colonel Xenakis stated that the key component is the Lead Agent must know the defined population, what the current and projected utilization will be, the cost of services to be rendered, and be able to project changes in delivery mechanisms. Similarly, Captain Goodman stated that the key component is the matrix (Table 2) that defines responsibilities for the MTF and contractor. The capitation-based matrix incentivises MTFs to move into their most efficient organization, namely to downsize inpatient capability to the extent possible. Captain Goodman further contended that the regional air evacuation routes need to be realigned to create greater efficiency of resources.

In the area of lessons learned, the responses from the key personnel were not surprising. BG Spaulding stated that because issues were still evolving at DoD and with Congress, it was difficult to devise a plan around a "moving target." In addition, he stated it was a difficult process trying to write one statement-of-work for 16 MTFs. Along these same lines, Colonel Mally stated that the critical lesson was that the vision of health care delivery is locally focused, based on the unique capabilities of the MTF and population supported. Second, the Lead Agent is responsible for the care of all patients, both in the facility and outside of the four walls. Similarly, Colonel Xenakis indicated that the principle lesson is that the range of capabilities amongst the MTFs is broad and the orientation

between the three services is very diverse. Conversely, Captain Goodman's response referred to the need to start the develop of the health care plan early and adequately staff the Lead Agent office at the outset, actions he felt Region III did not do.

Concerning the visit to Region IV, Keesler AFB, BG Spaulding and Colonel Mally stated that they felt that the visit was positive. It gave the key personnel an opportunity to "bond" with their counterparts and revealed the different approach each region is taking in developing their plans. However, Colonel Xenakis stated that the visit "compromised our intent to design and implement a plan that we felt was more suitable to the services requirements." The visit caused Captain Goodman to realize the "stark difference" between Region III and IV. As he stated, Region IV was content to accept the TRICARE contract as written. Region III, on the other hand, was more inclined to make the contract fit the specific needs of the MTF Commanders in the region.

In addition to being the Lead Agent for Region III, BG Spaulding also commands the Southeast Health Services Support Area (HSSA), responsible for integrating the health care provided to Army beneficiaries in the region. The Southeast HSSA includes the states of Alabama, Florida, Georgia, parts of Kentucky, Mississippi, and South Carolina. Due to his dual-hatted role, the author asked him how he felt the Lead Agent and HSSA concepts will work out, particularly in terms of the geographical overlap of the regions. BG Spaulding stated that he thinks this is a

problem. He pointed to a potential scenario that could evolve in the future whereby the EAMC Commander may need to make financial decisions to move resources within the Lead Agent. At the same time in the role as HSSA Commander, he may be required to make decisions regarding the mobilization of physician resources. Because some of his HSSA assets are in Region IV, he pointed out that there could be a perception that "I'm not going to be fair to the MEDDACs that are outside of my Lead Agent." He further stated that although the Lead Agents (i.e., Region III and IV) may have letters of agreement and memorandums of understanding between each other, the potential for conflicts still exists.

BG Spaulding also offered some recommendations to other Lead Agents who will develop their health care plans in the future. He recommended that the Lead Agent Commander and the Lead Agent coordinator visit each MTF in the region. Once each MTF is visited, a general Regional Advisory Council (RAC) meeting needs to be held where the MTF Commanders meet initially followed by a working-level meeting for their Lead Agent staffs to "iron out details, similarities, and differences." Finally, BG Spaulding stated that he would not have done anything differently in the process of developing the health care delivery plan. The current challenge is to try to coordinate further communication between the Lead Agent, MEDCOM, the Surgeon General's office, and Health Affairs.

Colonel Mally and Colonel Xenakis were asked to comment on the impact of the video-teleconferences with the Surgeons General

and their staff on the development of the regional health plan. Colonel Mally stated that for the first time all three Surgeons General were exposed to the issues that Regions III, IV, and VI are working with. Although the effect on the Region III health plan will probably be minimal, he felt that the Surgeons General exposure to the issues has made them more knowledgeable and they will be more effective in dealing with the issues that arise from the DoD regions. Colonel Xenakis concurred by stating that the meetings have been helpful, particularly in terms of facilitating coordination between EAMC, MEDCOM, and the Office of the Surgeon General.

Because of his involvement as a member of Task Force Aesculapius, Colonel Xenakis was asked to comment on the apparent link between the downsizing of the military and the development of the regional health plan. He stated that process of designing and reorganizing the AMEDD was done in the context of having a vision of how the AMEDD would look in the future. The task force had to look at how the smaller AMEDD would function in a smaller uniformed service. In doing so, the TRICARE element or "contract pillar" was examined to determine its' feasibility with the desired smaller force structure. It appeared that Colonel Xenakis' membership on Task Force Aesculapius enabled him to examine, more clearly, the feasibility of the health plan based on the AMEDD's proposed reorganization.

The author also discussed the developmental process with the Coordinated Care Division, EAMC, and the DoD Region IV Lead Agent

Office, Keesler Air Force Base. Mr. John McDonald, Coordinated Care Division, functioned primarily as the initial Lead Agent Office cell beginning in October 1993. He stated that the lack of a Lead Agent Project Officer on board prior to January 1994 appeared to impede the developmental efforts of the plan during the initial stages. It was his contention that Region III's full commitment to the development of the plan did not occur until the Project Officer came on board in January 1994 (McDonald, 1993).

The interview with representatives from Region IV revealed a marked difference between the two regional approaches to developing their plans. Region IV brought in approximately 20 personnel from their region at one time for a two to three week period and developed their regional plan. However, the scope of MTF Commander flexibility that was attempted in Region III was not sought in Region IV. Thus, their focus was slightly different.

Major feedback from the interviews as a whole indicated the following:

- The process of developing the regional plan was very dynamic and fluid.

- The site visits played an integral role in setting the tone for the flow of information from the MTFs to the Lead Agent; this created a common bond between the MTFs and assisted in enhancing communication between the services.

- The development of the plan appeared to create a certain trust and confidence among the MTFs concerning the Lead Agent

Office's ability to coordinate activities between the regional MTFs and the Managed Care Support Contractor.

Case Study on the Regional Health Services Plan

The "Case Study on the Development of Regional Health Service Plans" was a very comprehensive document that provided fairly definitive guidance for Region III's planning efforts. The two major sections of this document were the "regional health care environmental assessment" and the "health services plan development." The environmental assessment section was used by MTF Commanders and the Lead Agent to:

1) Determine demographic attributes of the region.

2) Assess the use of the health care system through direct and non-direct means.

3) Determine institutional, professional, and financial resources needed to meet current and projected requirements.

In determining the demographic aspects of the region, each MTF Commander identified the following: DoD beneficiary population within the region; the size of the DoD population relative to the total civilian population; ways the beneficiary population is changing; the eligibility status of the beneficiary population; and other demographic specific areas.

In assessing the use of the military health care system, MTF Commanders determined where DoD beneficiaries were receiving care (i.e., inpatient care provided to eligible beneficiary in civilian medical facility). This information was critical as MTF Commanders determined historical regional utilization "baselines"

for future services. In addition, this baseline will be very important in determining expected referral volumes and acuity of patients (DoD OASD (HA), Nov 1993).

In assessing health care resources in the region, MTF Commanders identified the type of care available in their areas (e.g., medical, surgical, psychiatric). They also identified the level of care (primary, secondary, tertiary, or Specialized Treatment Service), the setting of care, and the volume of expected care that would be referred to other regional medical facilities. An assessment of resources gave the MTF Commanders the ability to analyze their access, quality, and cost issues in their respective local areas.

Chronology of Significant Events

The author attended key meetings here at EAMC and other locations, when possible, to stay abreast of the regional plans development. As previously stated, the scope and detail of these meetings varied considerably. In order to map out the plans development from "infancy" through "adulthood," the events the author deemed significant were captured (Appendix G). This chronology is by no means all inclusive of every meeting, debate, or decision made concerning the health plan. Moreover, it represents the author's attempt to synopsize key junctures in the developmental process.

For simplicity, the author characterized the development process into four phases: the Initial Planning, Individual MTF Plan Formulation, Regional Plan Formulation, and Regional Plan

Modification and Completion.

The Initial Planning phase represents the activities conducted by the EAMC Coordinated Care Division and concludes with the initial planning meeting held by the Lead Agent Project Officer and his staff. This phase began in October 1993 and concluded in January 1994. The Initial MTF Plan Formulation phase represents the period whereby the MTF Commanders concentrated on formulating a localized plan based on their capabilities. The Lead Agent Office allowed and encouraged the Commanders to exercise maximum flexibility in designing their plans.

During the Regional Plan Formulation phase, the local MTF plans were combined. During this three month period, there was significant coordination between the MTF Commanders, the Lead Agent Office, the three services Surgeons General, and DoD Health Affairs. Significant debates centered around the ability of the Lead Agent Office to modify the existing Region XI contract into one that more accurately reflects the spirit of flexibility desired by the MTF Commanders. In addition, the allocation of Champus funds represented some significant differences in opinion among the services. This phase culminated with the Assistant Secretary of Defense (Health Affairs) disapproving the Region III concept involving maximum flexibility.

Health Affairs' decision led to the final phase of the plans development, the Regional Plan Modification and Completion. The intent of Health Affairs' guidance was to ensure that the Tricare

concept looked the same in each of the twelve regions. This decision virtually squelched much of the flexibility Region III desired concerning their ability to determine the functions that the MTF Commanders they would perform. Instead, Health Affairs dictated what service center functions would be completed by whom (MTF or contractor).

This modification of the regional plan represented a significant rewrite by the Lead Agent staff. It also represented a reexamination by MTF Commanders as to their local plans. Once this modification was complete, the Region III Health Services Plan was quite comprehensive. For simplicity and ease of understanding, the author summarized the plan's key points below.

Summary of Regional Health Services Plan

The primary emphasis behind the DoD Region III Plans' concept was that it promoted local accountability and a degree of flexibility in health care delivery systems. One of the key pillars of the Region III Plan is that it is a requirements driven plan. It is an amalgamation of local catchment area plans developed by the MTF Commanders in this region. From catchment area plans the Lead Agent office aggregated the requirements and assembled the regional plan.

The Region III Health Services Plan consists of five main sections: 1) Overview, 2) Internal Environment Assessment, 3) External Environment Assessment, 4) TRICARE Service Center Options, and 5) TRICARE Eleven Essential Elements. Due to the size and complexity of the Plan, the complete plan is not

included in this paper. However, the author has synopsized the major sections of the plan below.

Overview

The TRICARE Region III overview section provides a basic snapshot of the general features of the region. There are 16 separate medical commands in the region, the capabilities of each MTF are varied, the local political and competitive environments are incongruent, and the eligible beneficiary population of over 1 million represents one of the largest in the DoD. In addition, this section indicates that several of the facilities in the region have been affected by Base Realignment and Closure decisions and others may be affected in the future.

Internal Environment Assessment

This section provides an individual environment assessment of each MTF in the region. Some of the key areas addressed included beneficiary population served, the levels of care available at the facility (primary, secondary, or tertiary), and ongoing initiatives. For example, several of the MTFs have partnership agreements in place that will be terminated and converted to memorandums of understanding once the TRICARE Support Contract starts. Other MTFs have a desire to increase primary care utilization and access through the establishment of coalitions with local health care facilities. Although not comprehensive, this section provides what the MTFs view as key internal factors in their environment.

External Environment Assessment

Consistent with the Internal Environment Assessment, each MTF highlighted some of the unique external factors that can and may impact the delivery of health care in their respective areas. Some of the areas discussed include the political climates in the communities, the health care systems in the community (e.g., PPOs, HMOs, VA hospitals), and the sharing agreements or joint ventures with outside facilities that exist. In addition, the top ten highest government cost CHAMPUS diagnostic categories for FY 92 or FY 93 are given. Again, the section was not intended to be comprehensive, but to provide a snapshot of the varying levels of care available in the region.

TRICARE Service Center Options

Because many of the MTF Commanders in the region already have functional managed care delivery systems, or portions of systems, it was the Lead Agent's desire not to squelch their initiatives by turning over managed care functions or options to a contractor. However, the Assistant Secretary of Defense (Health Affairs) directed that there be limited options built into the Regional Plan. The limited options will give the MTF Commanders a degree of flexibility and control by establishing business mechanisms to administer the TRICARE Program.

The Options section of the Plan states that each MTF will: 1) Continue to operate its own MTF Appointment Systems, 2) Continue its own Utilization Management and Quality Assurance Programs, 3) Provide Health Benefit Advisor services, 4) Administer its Third

Party Collection Program, and 5) Issue its own non-availability statements, if they have the authority to do so. In addition, this section spells out desires of the MTFs regarding the location and anticipated square footage available for the TRICARE Service Centers. A chart identifying all of the options is at Table 2. On the chart, functions the MTF is responsible for are identified with a N; the contractor is responsible for functions identified with a Y.

TRICARE Eleven Essential Elements

The Regional Health Services Plan is also supported by eleven essential elements, synopsized earlier in this paper. Each MTF identified its' ability to incorporate the essential elements into their local plans. The local MTF plans were then aggregated to formulate a "Regional Concept of Operations." The "Regional Concept of Operations" was designed to provide regional policies and procedures to fulfill the requirements spelled out in each element.

In summary, the overarching theme behind the development of the Region III Health Services Plan was that it allowed local MTF Commanders the flexibility to improve access to health care, maintain the quality of health care delivery, control the growth of health care costs while maintaining beneficiary freedom of choice. The Plan was designed to accomplish several objectives: 1) Build partnerships with the contractor, 2) Facilitate the sharing of resources in the region, 3) Optimize the MTFs capabilities, and 4) Create an atmosphere in which the MTF is the

"hub" for the delivery of medical care to DoD eligible beneficiaries, and all its surrounding medical assets (civilian and military) are the spokes (Crispell, 1994).

Y=contractor responsibility
N=MTF responsibility

TABLE 2
SERVICE CENTER FUNCTIONS

	GORDON	BENNING	MCPHERSON	STEWART	MOODY	ROBINS	JACKSON/SHAW	CHARLESTON	BEAUFORT	MACDILL	PATRICK	JACKSONVILLE	ORLANDO	KINGS BAY	KEY WEST
INFORMATION/ASSISTANCE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
SPECIALTY REFERRAL/SCREENING	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CIVILIAN APPOINTMENT SCHEDULE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MTF APPOINTMENT SCHEDULE	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
NAS ISSUANCE	N	N		N	N	N	N	N	N	N	N	N			
CIVILIAN UTILIZATION MANAGEMENT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CIVILIAN QUALITY ASSURANCE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CHAMPUS ELIGIBLE ENROLLMENT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MARKETING/EDUCATION	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
DEERS ACCESS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MTF UM	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
MTFQA	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
HBA SERVICES	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
ACTIVE DUTY ENROLLMENT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
PCM ASSIGNMENT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MTF INTERFACE	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
GOVERNMENT FURNISHED SPACE *															
GOVERNMENT FURNISHED EQUIPMENT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NETWORK PROVIDER RECRUITMENT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
NETWORK PROVIDER CERTIFICATION	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
PROVIDER EDUCATION/RELATIONS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MTF CONSULT REQUEST PROCESSING	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
ENROLLMENT FEE COLLECTION	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CONGRESSIONAL/PUBLIC INQUIRIES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
APPEALS	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
GRIEVANCES	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CASE MANAGEMENT	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
THIRD PARTY COLLECTIONS	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N

*see Part 2, Addendum A, Section J

Lessons Learned

In an effort to gain a better perspective on some of the lessons learned as Region III developed the health plan, the author talked to some of the key players on the front lines. As previously stated, BG Spaulding, Colonel Xenakis, and other key players in the plans' development were interviewed and asked what they felt were some of the key lessons learned. Their complete responses to this question are included in the appendices. However, for brevity, the major lessons learned from their responses are synopsized below:

1) Get started early. Ensure that the Lead Agent cell is adequately resourced (i.e., personnel and equipment) prior to being required to give guidance and direction to regional MTFs.

2) The health care delivery vision is localized. Due to the diverse capabilities of regional MTFs (e.g., patient population, private sector medical capabilities), the vision for a community must be tailored to fit its' medical environment. The local MTF is responsible for the care of all local eligible beneficiaries whether they receive care in DoD facilities or not. In addition, the localized vision can be compounded by the diverse orientation between the three services (i.e., how Champus funds are allocated).

3) It is a difficult process. With 16 MTFs in this region, writing one statement of work for the region was difficult. Because the region tried to maintain as much flexibility in the health plan as the MTF Commander's desired, this translated into

a potentially complicated statement of work.

Discussion

The Interview Process

In his article discussing community healthcare programs, Rauber (1994) stated that community ownership is the idea that for any health care initiatives to work and to be sustainable, the community must have a central role in designing, running and controlling those programs. The author's interviews with the key personnel in the process revealed the Lead Agent Offices' attempt to do precisely that - give local MTF Commanders the latitude to design and control their destinies through their health plans.

In projects of this scope and magnitude, the potential for miscommunication or lack of communication on key issues can be multiplied several times. However, the author found that the key personnel in the health plans development, from the "visionary" to the "worker bee", remained consistent in their philosophical direction concerning what the regional health plan should look like. They operated with a common theme that encouraged maximum flexibility at the MTF level. Although each of the key players came to their respective positions with varying levels of experience and expertise (see Table 3), each focused on working collectively to produce the regional plan.

Table 3. - Profile of Key Personnel Interviewed

NAME	YRS SERVICE	PREVIOUS POSITIONS
BG Spaulding	26	- Special Assistant to President, Health Care Task Force - MEDDAC Commander (twice) - Deputy Commander for Clinical Services (DCCS)
Colonel Mally	26	- MEDDAC DCA (twice) - MEDCEN Executive Officer - Evacuation Hospital Commander
Colonel Xenakis	23	- Task Force Aesculapius Member - MEDDAC Commander - DCCS
Captain Goodman	7	- MEDCEN Chief, Resource Management Branch - Medical Company Commander - Assistant Division Surgeon

Chronology of Significant Events

As previously stated in this paper, the process of developing the Region III Health Services Plan was quite fluid, with the level of coordination and input to the final plan equally extensive. In addition, the "baggage" or idiosyncrasies inherent with each of the three services only compounded the degree of education required of each MTF Commander to learn how business is done by their sister services.

Not surprisingly, debates on unclear issues, such as the degree of MTF Commander control over Champus dollars or who is responsible for performing utilization management, were discussed at the Region III level and are still being discussed locally and at the DoD level. One Army official commented in a recent

publication that the Army has a philosophical difference from the Navy and the Air Force concerning contractor requirements. He stated that the Navy wants the contractor to do everything that can't be done by the Army, the Air Force prefers that utilization management be done by the contractor, whereas the Army thinks it can do those things (Anonymous, 1994). Further, potential contractors in other regions have voiced concern over the Tricare provisions, with one expressing his displeasure with the stipulation that hospital commanders have considerable authority over contractor actions. These concerns have led to congressional hearings and inquiries in other DoD Lead Agent regions as to the MTF Commander's span of control (U.S. Medicine, 1994).

Although some of these recent events that have transpired remain unresolved, the author still contends that the process the Region III Lead Agent adopted to complete the health care plan was a viable one, one that produced a document that is "community" based and locally designed.

Lessons Learned

The development of the Region III Health Services Plan was a major undertaking and not an easy process. As with many major projects where blueprints exist but have yet to be executed, there are lessons to be learned for those that will follow. This project was no exception. The process of developing the regional plan has provided some lessons learned.

Undoubtedly, DoD Lead Agents that will undertake the

development of their regional health plans in the future will experience unique challenges. Their "growing pains" may be mild or severe as their regional plans reach adulthood. The lessons learned from Region III merely provide a frame of reference from which other regions can learn and gain further insight into "a" method, but not necessarily "the" method they should follow in developing their plans.

Conclusions

During this research, the author observed, analyzed, and documented how the DoD Region III Health Services Plan was developed. The interviews with the key personnel revealed that the managed care efforts being adopted by DoD are designed to enhance cooperation among regional MTFs and empower local MTF Commanders to "call the shots" as they work with the Managed Care Support Contractor. In an environment that is projected to have a smaller uniformed force, this enhancement invariable should result in a military medical support structure that integrates, philosophically and conceptually, with the Health Security Act proposed by the President.

The basic tenets of the Managed Care Program are embodied in the Region III Health Services Plan, namely that medical readiness be maintained for military operations and that those entitled to DoD medical services receive it. Because the plan has not yet been implemented, the author contends that it is too early to gauge its impact on the regional beneficiaries.

However, once implemented and MHSS resources are optimized, the desired impact on the beneficiary is that greater equity should be achieved in the areas of access, quality, cost, and benefits received. Again, taken collectively, these TRICARE initiatives will be consistent with the national health care reform efforts currently underway.

Recommendations

The author recommends that this research be used by other Lead Agents as a benchmark or an additional resource document as they undertake the developmental process. For Lead Agents already in the midst of developing their respective plans, this research may assist in averting obstacles or streamlining procedures.

In addition, due to the transitory nature of military personnel, the author recommends that this document be reviewed by newly assigned Region III Lead Agent staff so that they may gain a historical perspective on the debates and subsequent decisions that yielded the regional plan. Finally, this document may be able to answer future questions concerning why DoD Region III functions as it does.

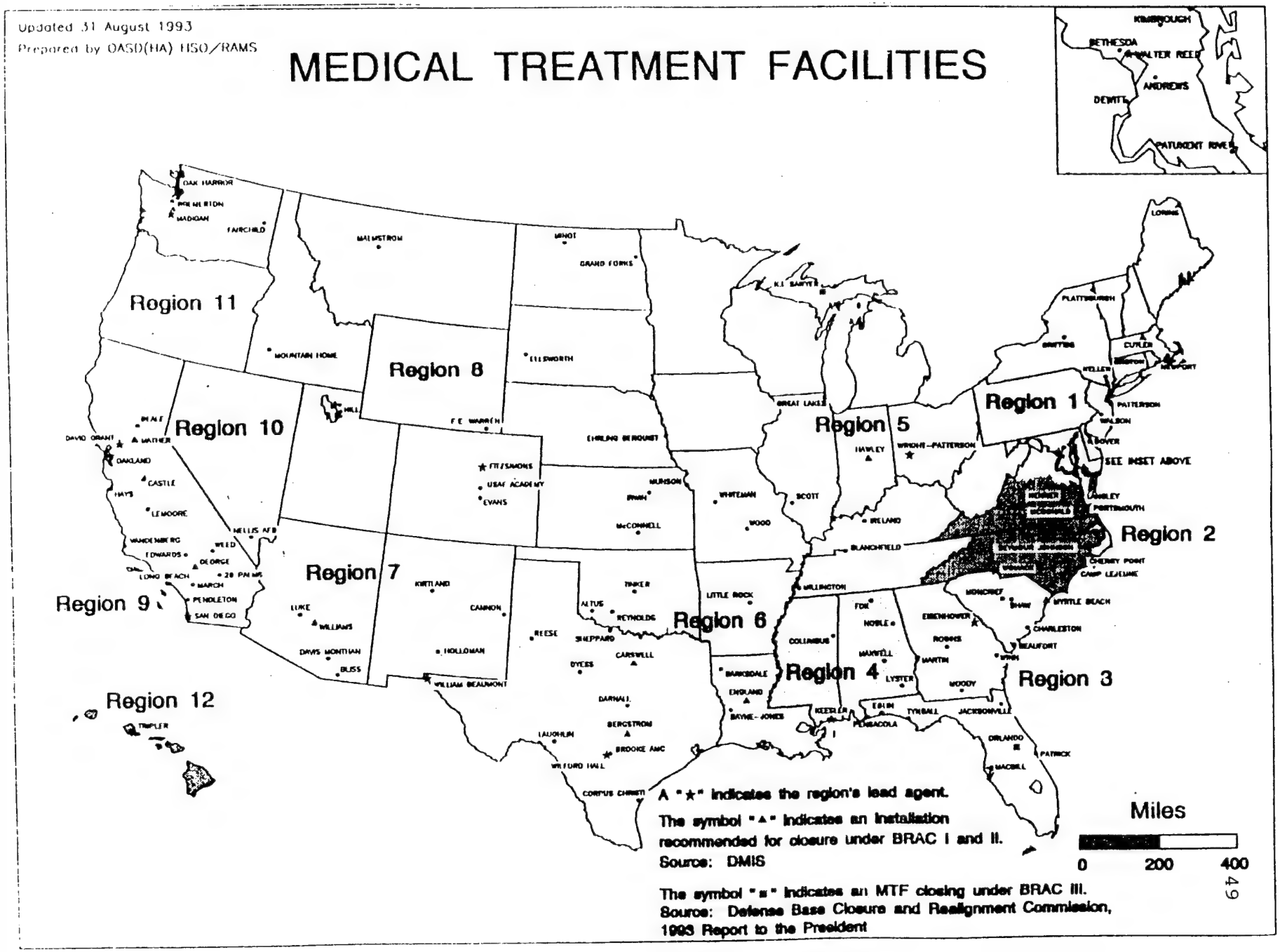

Fig. 1. Reprinted from A Specialized Treatment Services look Across the New DoD Health Service Region, OASD (HA) HSO/RAMS (Washington, n.d.)

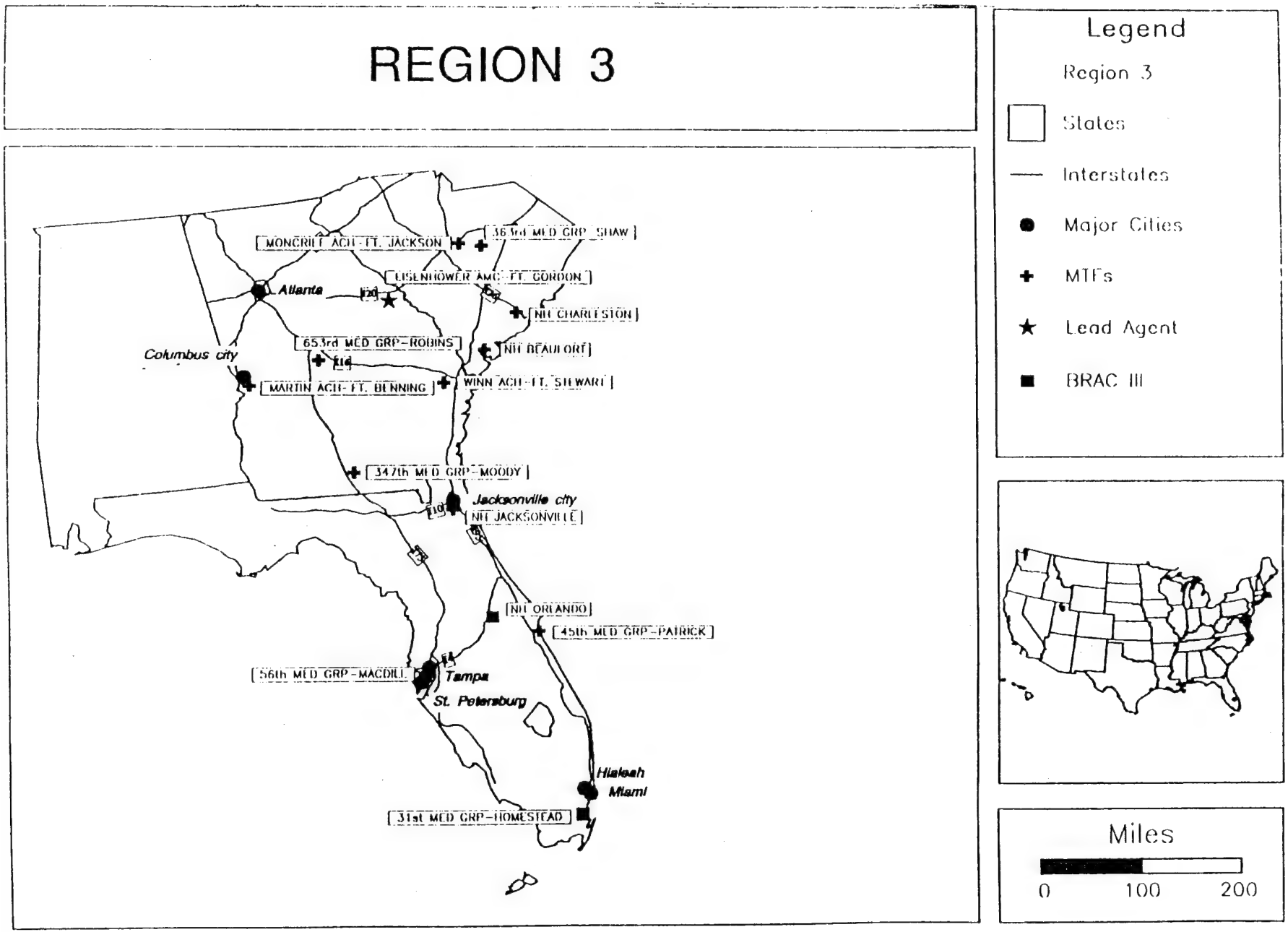

Fig. 2. Reprinted from The Assistant Secretary of Defense memorandum entitled "Regionalization of the Lead Agent Concept", OASD (HA) HSO/OMS/DMIS (Washington, 1993)

ARMY HEALTH SERVICE REGIONS

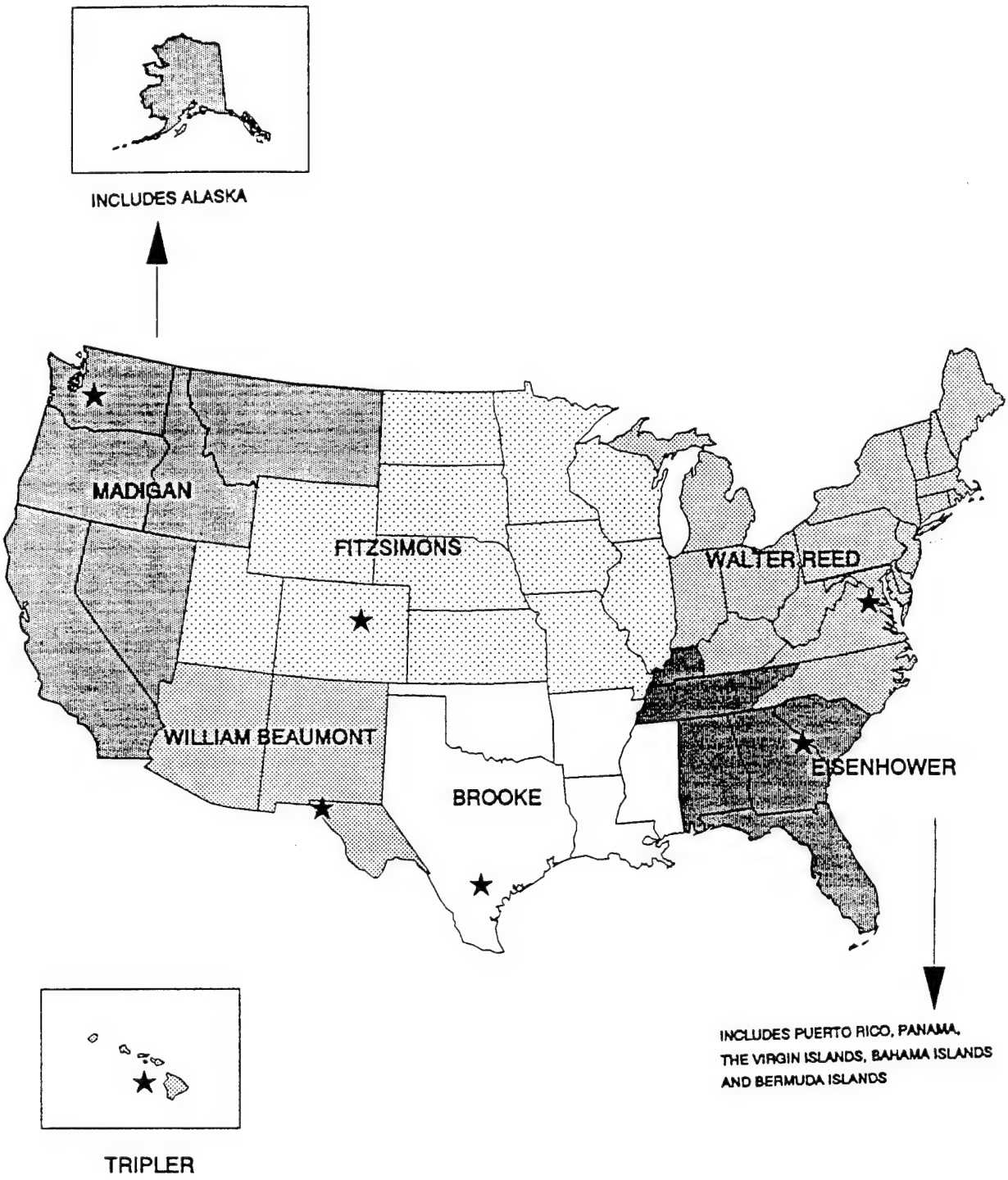

Fig. 3. Reprinted from Eisenhower Health Service Region Medical Mobilization Readiness Program Seminar, EAMC (Atlanta, GA 1992)

Dwight D. Eisenhower Army Health Service Region

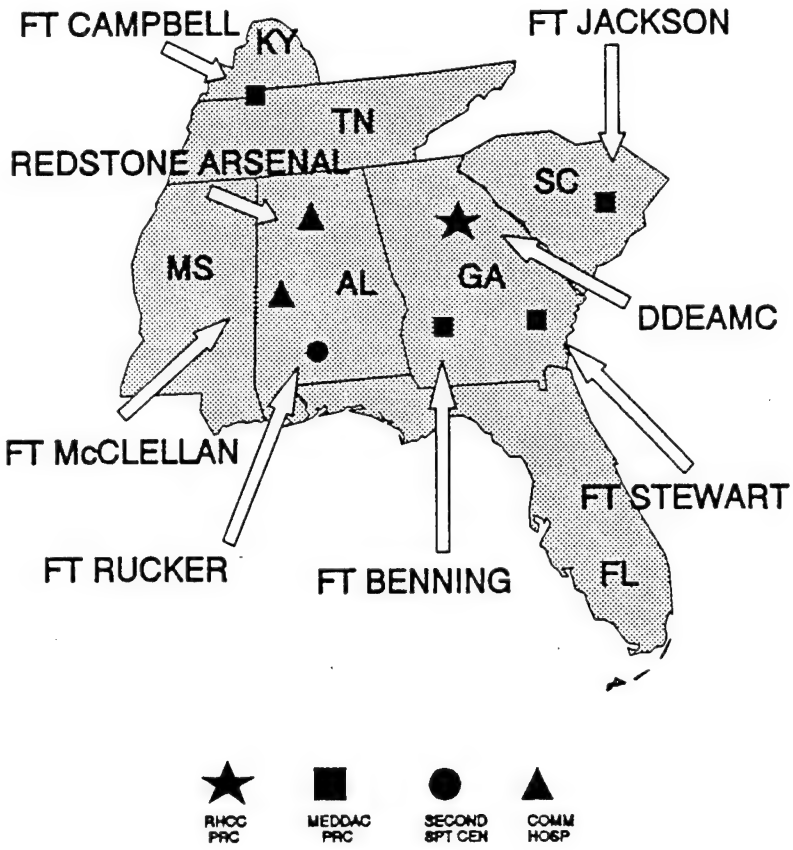

Fig. 4. Reprinted from Eisenhower Health Service Region Medical Mobilization Readiness Program Seminar, EAMC (Atlanta, GA 1992)

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APPENDIX A

DEFINITIONS

Definitions

Capitation: A set amount of money received or paid out, based on membership rather than on service delivered, usually expressed in units of per member per month (PMPM).

CHAMPUS (Civilian Health and Medical Program of the Uniformed Service): A program administered by the Department of Defense, which pays for care delivered by civilian health care providers to retired members, and dependents of active and retired members under age 65 of the seven uniformed services of the United States.

CHAMPUS Reform Initiative (CRI): Contracted care for a region that was established to control medical expenditures.

Coordinated Care Program: A Department of Defense initiative designed to provide MTF Commanders the tools, authority, and flexibility needed to better perform the health care and medical mission. This program represents the DoD equivalent to managed care.

Health Maintenance Organization (HMO): Prepaid organizations that provide for health care in return for a preset amount of money on a per member per month basis.

Managed Care: The delivery of high-quality health and medical services at a competitive price. This involves proper planning, organizing, directing, controlling, and coordinating of health care delivery.

Preferred Provider Organization (PPO): Insurance plans that encourage subscribers to seek care from selected hospitals, doctors, and other providers with whom they have established a contract. The contract generally includes both price and utilization restrictions, and the subscriber is rewarded with a higher level of insurance coverage.

Primary Care: The point when the patient first seeks assistance from the medical care system and the care of the simpler and more common illnesses. The primary care provider usually also assumes ongoing responsibility for the patient in both health maintenance and therapy of illness.

Regional Advisory Council (RAC): An executive group, chaired by the Lead Agent Commander, made up of the regional MTF Commanders. Their job is to make decisions regarding how the three service's MTFs should align themselves and advise the Lead Agent on matters pertaining to the region.

Task Force Aesculapius: a special task force, formed in late

1992, to study the structure and organization of the US Army Medical Department (AMEDD). The task force would also make recommendations to a senior executive council, headed by the US Army Surgeon General, for the AMEDD reorganization.

Triple Option: The offering of an HMO, a PPO, and a traditional insurance plan by one carrier.

APPENDIX B

INTERVIEW WITH BRIGADIER GENERAL VERNON SPAULDING

Graduate Management Project Interview

DATE: March 16, 1994

INTERVIEWER: Author

INTERVIEWEE: Brigadier General Vernon C. Spaulding, Commander, Dwight David Eisenhower Army Medical Center and the Southeast DoD Region III Lead Agent

Question: What do you see as the major missions, functions, and responsibilities of the Lead Agent, particularly in this region?

Answer: I think the way things are set up now, the main responsibility of the Lead Agent is to be the organization that organizes the care for Region III. We're primarily the agent that will consolidate all of the multiple treatment plans in the region into one plan. Out of that one plan will come the Statement of Work that describes what we want the contractor to do. There has to be an organizer and we are the organizer.

Question: Realizing that you were on President Clinton's Health Care Task Force, how is the Lead Agent concept expected to integrate into President Clinton's health care reform initiatives?

Answer: I think the biggest thing is that there are major components of Clinton's health care reform initiatives and his proposal and whatever we do in military medicine should reflect those things. A good example would be choice. It is very

important in Clinton's plan that the beneficiaries be afforded a choice, having a number of plans to choose from. Clearly, as we evolve in our Lead Agent and our Tri-care plan, it will be very important for the beneficiaries to either choose one, the military plan which is our Tri-care Prime, or some type of PPO option or some type of fee-per-service option. They should have those choices.

Question: How were you involved in the health care delivery plans development?

Answer: I've been intimately involved in the plans development as we've gone along. The key thing is that we needed a senior person with organizational and managed care skills along with a hospital commander's background and a readiness background to be the person on the ground doing the day-to-day work. Because of my job and all the other things I have to do as the commander, this would not be something I could do day-to-day. So this is the reason for choosing somebody like COL Xenakis. Certainly, I am very pleased to have him on board because of his experience.

Having said that, clearly I'm the leader and I have taken an active role initially by setting the atmosphere. I, myself, went out and visited every single hospital in our region. The purpose of the visits was primarily the bonding issue, making contact, and developing that trust. I did get briefings as I went to each place as to their basic facts of their MTF, meaning

how many people are in the region, how many are Champus eligible, how many dollars were spent, what were the Champus expenditures the last three years, and what general direction do they think they can go as related to managing their own affairs. I got that type of briefing as I went around, but my main purpose was to set up a right atmosphere. They saw me directly. I saw them. I got a feel for their MTF so as we go down the road of getting to real tough decisions, barriers were broken down. I've been intimately involved in that part.

As the program is beginning to get written down as far as our regional plan, and the representatives of each of the MTFs have been here, I have pretty much gotten an every two or three day briefing as to what the progress has been. So we've done it both ways, on a global/regional basis and I've been briefed on each individual MTF.

Question: As a follow-on question, what do you think will be the key components of the health care delivery plan?

Answer: The key components or the key philosophy is that we really want to foster management of each of the MTFs in their own catchment area. We want to set an atmosphere such that each MTF can manage as much as they are capable of managing before the contractor comes into their catchment area. In other words, we want to set an atmosphere in which the contractor supplements the MTF rather than the other way around. I want to have an

atmosphere in which, as much as the MTF commander can handle, he or she is calling the shots.

Question: What do you think were some of the lessons learned as we developed the health care plan for this region?

Answer: I think so far, as we are still early, it's a very, very tricky exercise in that many of the rules haven't been passed yet. Things are still evolving at DoD and with Congress. It's sort of like there is a target and standards. That target and standard can potentially move. And like what I was just talking about today concerning these cost shares, these cost fees: these are proposals. Are they going to really be in law? We don't know! There's so many moving targets. They are trying to devise a plan around moving targets and it is difficult.

The other part that I have learned is that it is a very difficult process, trying to get 16 MTFs together and to write one statement of work. What the contractor needs is a very clear, simple statement as to what he or she is accountable for and if, as I've mentioned to you, that I'm striving for flexibility, each MTF is going to do a slightly different thing because of capability. That right there tells you that there's a lot of potential for a very complicated statement of work and trying to translate that into dollars (how many dollars will the contractor get, how many dollars will I keep before the contractor comes in, and what will be the bid-price-adjustment

relationships when you don't do as much as you say you were going to do), and how you write that can be a lot more complicated than just talking from a theoretical, regional standpoint.

Question: What impact do you think the recent visit to Keesler Air Force Base will have on our initiatives in this region?

Answer: I think that the Keesler visit was very important for two reasons. One, it was a bonding issue in that I got to meet Colonel Diver and his staff, and he got to see me, Colonel Xenakis, and Colonel Mally. We got to hear, generally, what direction they were going in, but I think more importantly, they got to hear us. They got to hear that we were moving towards a catchment area management philosophy, that we were trying to give each MTF maximum ability to manage and I got the feeling that he embraced that thought. I got the feeling that there would be an effort to make sure that our language is very similar as we move towards the RFP writing time so that when we meet DoD, whatever perceived differences between the two regions would be pretty much minimum. In other words, we'll be talking the same language. I think it was a very, very useful meeting.

APPENDIX C

INTERVIEW WITH BRIGADIER GENERAL VERNON SPAULDING

Graduate Management Project Interview

DATE: June 6, 1994

INTERVIEWER: Author

INTERVIEWEE: Brigadier General Vernon C. Spaulding, Commander, Dwight David Eisenhower Army Medical Center and the Southeast DoD Region III Lead Agent

Question: Where are we now in terms of the health care plans development and the Request for Proposal?

Answer: A decision was made by Admiral Martin to have the contract for Region 3 and 4 go on the street at the same time. After that decision was made, the plan was to try to get me and Colonel Divers to have as close to a similar regional plan as possible. That would allow us to go into the RFP for the two different regions as consistent as possible.

This was unsuccessful because Colonel Divers was taking his cues from General Anderson of Region 6 and General Anderson's decision, primarily, was to stay with the previous concept of Region 6/Region 11, which was a CRI-related type contract. Our concept was to try to push for the capitation budget philosophy of the maximum autonomy and ability for each MTF to manage their catchment area. That meant when we sat down with Admiral Martin on April 19, I did not have a harmonious regional plan with Region 4. Region 4 had a different concept than Region 3. Admiral Martin approved Region 4 quickly because that was a standard contract. But he, essentially, disapproved our concept

saying that, from their point of view, it's not an at-risk contract, all of the CHAMPUS dollars will go to the contractor, and Region 3 must come in line with Region 4. Our regional plan and our initial preparation for the RFP was based on that type concept.

At that point I communicated with LTG LaNoue and MEDCOM. LTG LaNoue felt very strongly that the concept that we were marching under in Region 3 was the type of thing we should be pursuing Army-wide. He felt that this was very, very important and it was more than just Region 3. He felt that, as an AMEDD, we needed to continue to pursue the concepts we were talking about.

Separate to that, he had tasked BG Burger to develop a task force to develop a suggested format for an RFP. That was done and several people were involved in that effort, to include Colonel Xenakis. A straw-man was drafted that identified what the Army's position would be on the RFP and it had in it most of the things that we wanted in Region 3.

Over the next few weeks LTG LaNoue met with Dr. Joseph, who had become the Assistant Secretary of Defense for Health Affairs and Admiral Martin had become his Deputy. However, he did not succeed in changing Dr. Joseph's mind. Basically, Dr. Joseph said that he was supporting the concepts that Admiral Martin was already supporting and he was not ready to change. He did leave a little opening to say that the concepts that Region 3 wants to do are concepts that make sense, but the changes need to be done

incrementally.

In mid-May, I got a call from Admiral Martin's office reminding me that our meeting in April with him resulted in our concept being disapproved and that the RFP needed to be redone in the concept of Region 6. Basically, Colonel Xenakis and LT Crispell have been reworking the RFP over the last few weeks, namely taking out most of the innovative things that I wanted in it. What I wanted was to be able to continue alternate use projects, things that were done with CHAMPUS dollars, and to be able to role those over to our corps budget once the TRICARE contract was started. Marty Kappert's (Health Affairs) answer was that I could do whatever I want to do with alternate use dollars, but once the contract gets let, it's up to contractor to decide whether those things are cost effective and in the best interest of him to continue. I wanted to be able to make that decision, regardless of what the contractor thought. If the things we continued were best for the Army and best for us, and they made good business sense, my position was we should continue them.

Basically, we have redone the RFP markup based on the Region 6 format and we are going to send that in to Health Affairs. We had a video-teleconference this morning with BG Burger, who was representing LTG LaNoue and BG Cuddy who was representing MG Cameron, and we all acknowledged the disapproval from Mr. Kappert's office concerning Region 3 initiatives. That's where we are locally.

From a corporate strategy standpoint, what I recommended and we all agreed to was that we still should pursue, at Dr. Joseph's level, some type of open forum to continue to discuss the issue in one of two ways. The preferable way would be to push for a delay. Because there have been so many challenges to the RFP from California and Hawaii, we need to have some time to go by to have some lessons learned from Region 11 and Region 6. If Admiral Martin and Marty Kappert are not willing to do what I want to do at this point, a compromise would be to hold it and see which way is the best way to go, let a year go by and see whether my concepts are as important as we think they are. That's a possibility.

We have redone our RFP in the format of Region 6. I didn't get my answers to my questions as I wanted them, but they've been asked. We're going to proceed as if we're "full steam ahead," but from a corporate standpoint, we're going to push for a delay at LTG LaNoue's level. The question is the implementation of all of that. There has to be an orchestrated meeting between Dr. Joseph and either LTG LaNoue or a representative of LTG LaNoue. If LTG LaNoue is unable to do that, the logical person would be BG Burger because he is our managed care person, or it might even be me. A way of getting Dr. Joseph to sit down with us would be to invite him to Region 3, because we're the controversial area.

Question: How do you think the Lead Agent concept and the HSSA concept will work out eventually, particularly in terms of there

being two distinct geographical areas of responsibilities for the commander?

Answer: I think it's a problem. There's going to be a significant advantage to have the HSSA and Lead Agent regions in harmony and not an overlap. The obvious things that would come to mind would be making business decisions that are important from the standpoint of Lead Agent. Once health care reform is passed, the question is "how much eventual power will they give each of the Lead Agents." The orientation is to take more and more from the services and invest more authority and responsibility in the Lead Agent.

If you look down ten years from now, and I as the EAMC commander had to make financial decisions to move physicians or move resources within my Lead Agent, but then at the same time, if on a mobilization posture my control is over my HSSA and I decide that certain medical units have to deploy and I have to come up with physicians, from an economic standpoint, everything else being equal, where would I go? Well, I go to Alabama because they are not in my Lead Agent. As long as you have this mismatch there's going to be a perception that I'm not going to be fair to the MEDDACs that are outside of my Lead Agent. Because if I took people from Alabama then the Lead Agent for Region 4, which would be Keesler, would be stuck with a loss of health care providers and would have to make up that deficit out of his region. As long as there is a potential mismatch like

that you have those potential conflicts. In reality, were going to try to have some letters of agreement, memorandums of understanding, and things of that nature, but still, you're going to have those little tensions.

Question: What recommendations would you make to other Lead Agents who will be undergoing this development process in the future?

Answer: I think each of the other subsequent regions are going to profit on what we've gone through here in Region 3 and Region 4, there's no question. If we win a delay, certainly, all the other subsequent regions are going to profit by also being in a delay mode waiting for lessons learned. If the lessons say that the delay tactic does not work and there's no congressional support for a delay, then I wouldn't do things any differently from what we've done.

I think we really did a fairly good job in coordinating and getting input from each of the MTFs. That was a major job with 18 different places. I traveled around to each place and saw each place. It was a full time job for Colonel Xenakis. We had at least three RAC meetings and everyone got a chance to express themselves. I would pretty much recommend that they do it the same way. Whoever the Lead Agent commander is, he or she must visit each place and I did that. You've got to go there to get a briefing, see the people, bond, and get an understanding of the

community. And then whoever is the Lead Agent coordinator has to either go with you or go separately because it's a different type of meeting; one is going to be a working meeting, the other is going to be more of a PR (public relations) type of meeting. Both of these things need to occur.

Once every place is visited, you need to have a general RAC meeting where the commanders get together and then after the commanders get together, you need some working-level meeting so you can iron out details, similarities, and differences. I wouldn't really change that process that we went through. I think the process that we used was a very good process.

Question: Looking back, would you have done anything differently?

Answer: I really wouldn't. Even in the fact that we had a very contentious relationship and continue to have one with Health Affairs, I think that we've managed to keep a line of communication open, so we're continuing to talk. And when I had problems here I did involve my higher headquarters. I think the challenge right now is trying to coordinate further communication between Health Affairs, the Surgeon General's office, MEDCOM, and me. That is a tough job, getting us all to talk and communicate with one voice.

APPENDIX D

INTERVIEW WITH COLONEL EARL MALLY

Graduate Management Project Interview

DATE: May 20, 1994

INTERVIEWER: Author

INTERVIEWEE: Colonel Earl B. Mally, Deputy Commander for Administration/Chief of Staff, Dwight David Eisenhower Army Medical Center

Question: What do you see as the major missions, functions, and responsibilities of the Lead Agent, particularly in this region?

Answer: In my opinion, what the assignment of these kinds of responsibilities to a Lead Agent represents is that you will now have an opportunity, a framework, if you will, to enhance cooperation among all DoD facilities within the region to provide care to eligible beneficiaries. That will be a much more effective way of focusing our health care resources on our eligible population and coordinate them on a regional level. Heretofore, Eisenhower as a tertiary care center in this part of the United States served customers based on a lot of other reasons, mostly availability, understanding of what service we had available and the ability to provide those services. In the future, we have a specific relationship with the DoD MTFs and a responsibility to provide tertiary care services. My notion is that now the MTFs in our region would be able to count on us for those services. We'd be able to grow and develop those services in support of our customers in Florida, Georgia, and South Carolina. This represents a completely different relationship

than we've had before. So I see that's one area that we can make a different kind of a contribution in the Lead Agent concept.

The other area I see is in the relationship, if you will, to the Managed Care Support Contractor. And again, the relationship, I think, will enhance the ability of providing the benefit structure to our patients because working as a partnership we can better organize and deliver services to our patients either in military MTFs or in civilian facilities or using civilian providers.

I think the essence of it is, one, of being a service provider to the MTF customers in our region, and secondly, to be a coordinator at Lead Agent in this partnership between DoD and a Managed Care Support Contractor.

Question: How is the Lead Agent concept expected to integrate into President Clinton's health care reform initiatives?

Answer: It fits philosophically and conceptually the Health Security Act proposed by President Clinton. In reality, it represents an idea that came out of the Jackson Hole Group and also from a very broadly based effort of a health care reform task force run by Mrs. Clinton. So what's before Congress today is in fact mirrored in the DoD TRICARE program. Specifically, that the employer has certain responsibilities to provide for health care benefits for the employees and that there will be a managed care component in the way care will be delivered. But

there will be a triple option available to all beneficiaries: an indemnity approach, a managed care approach called a preferred provider network, and then the ultimate in managed care organizations - a health maintenance organization. The notion is that because you incentivise providers to provide care for their patients, that doesn't reflect an economic incentive to do more, but to keep people healthy. You would realize, one, a reduction in health care costs because inappropriate or unnecessary medical services wouldn't be provided because the providers wouldn't be incentivised by volume or those kinds of things. And secondly, by focusing on keeping the patient healthy, you might improve their health status over time so that they don't require as much care. This is all consistent with and embodied in what the President has proposed.

Another central feature is enrollment. That is going to be an absolute requirement to manage cohorts of patients. You'd have a known number of beneficiaries, covered lives, that you would know what the benefit structure would be to deliver to them and you'd be able to do that within a certain global budget. All of those features are in the President's Health Act. But the essence of what we are going to provide through this Lead Agent or TRICARE concept is an accountable health plan. This is an aspect of the President's proposal that will be clearly seen in the TRICARE program. We would be accountable, both to our funding sources, the DoD, and to our patients to deliver a certain benefit structure to a certain group of patients.

Question: How were you involved in the health care delivery plans development?

Answer: My role was essentially an integrator of ideas, of people, of resources, to try to build a process by which the DoD MTFs and the representatives of those MTFs could, in fact, come together and provide their own vision and their input into our regional health services delivery plan. That included building the opportunity to educate them on what TRICARE was all about, facilitating the development of a relationship that didn't previously exist between this medical center and all of the MTFs in the region, and putting in place the resources to integrate input into the regional health services plan and then ultimately to produce the RFP.

Question: What do you think will be the key components of the health care delivery plan?

Answer: I think the number one component to me would be the question of enrollment. Without enrollment, where you know who you are responsible for, you can't adequately plan both the amount of service you need or even anticipate what the cost of the services will be. You have historical data, but since you're not controlling utilization at all, in fact, you never know how much service is going to be required by a certain group of patients. So in my mind, the enrollment feature is the key

component to making any TRICARE program work, at least the aspect of it that's MTF based. The MTF does have to know who they are responsible for and what services they will be providing.

The other component is that I still think there is a very positive spin to this partnership relationship between the MTF Commander and the Managed Care Support Contractor. I think working together they can, in fact, build a locally based health care delivery structure that will be responsive to the patients and will be able to deliver them in a cost effective way. I see that component of it to be a real positive one as well.

Question: What do you think were some of the lessons learned as we developed the health care plan for this region?

Answer: To me I think the critical lesson is that the health care delivery vision is a local vision. It's based on the capabilities of the MTF, patient population they support, medical capabilities of the private sector environment in their area. The ability to pull these things together in a coherent way reflects a shift in our previous way of thinking. And so we begin to understand our relationship to our patients outside the four walls of our institution. To me, this has been the clearest lesson learned that one, we're responsible to those patients whether they get care in our facility or not, and secondly, that it is a locally based equation, that virtually all of the care delivered is likely to be in the local market.

Question: What impact do you think the recent visit to Keesler Air Force Base has had on our initiatives in this region?

Answer: It was useful to exchange perspectives on how we're approaching our different regions, but in truth, we discovered that their region and the population in their region, their markets, are remarkably different from ours. They're not so different in Georgia and South Carolina, but they're remarkably different in Florida. Our approach to the market is going to be slightly different than theirs because Florida represents such a dynamic and growing market, a market that fluctuates seasonally, and the MTFs that are essentially available in Florida to provide services are relatively thin in their capabilities. So our analysis of our markets will produce a different approach than, essentially, the Keesler region. I think we were able to understand that and the differences between the two regions very clearly.

The positive thing that I saw was that it established good communication. We are now exchanging information about both of our regions and both of our approaches to solving the health care needs of our patients.

Question: What impact do you think the video-teleconferences with the Surgeons General have had on our process of developing the health plan?

Answer: One of the things I understood about that was that for the first time all three Surgeons General and their principle staff members were exposed to the issues that we're working with here and actually it's not just Region III. They were exposed to issues that were developed in Region VI, the issues that we see in Region III and Region IV, and I think there's a much better understanding of the challenge and what the implications are for the contract and the relationship of the future with the Managed Care Support Contractor.

What will the effect be on our health plan, probably minimal. But, in the long run, I think the understanding now of all the three star leaders of the services's medical departments is going to be enhanced and I think they'll play a more knowledgeable and effective role in dealing with issues that come out of the DoD regions.

Conceptually, what the relationship is with the Lead Agents is that the Lead Agent is still communicated to from DoD through the service Surgeon General. To the extend that they understand the TRICARE program and what the Lead Agents are doing makes them a much more effective leader for their Lead Agent.

Question: What impact do you think that the video-teleconferences with the Surgeons General has had on the Request for Proposal?

Answer: I think it clarified the issue that initially became the

most contentious which was "where the money goes." That's always the key issue. It had been soundly advocated that the CHAMPUS dollars that are associated with the TRICARE program go to the Lead Agent and the Lead Agent would be managing the flow of resources to the contractor. The basic flaw in that, of course, is that it changes the concept from one of an at-risk contract to one of essentially buying services through the Managed Care Support Contractor.

Clearly, the Navy and the Air Force Surgeons General and the Lead Agent for Region VI came on the net and said they would not support that basic philosophical change in the TRICARE program. I think there was more understanding developed on that specific key issue. But I think that one of the things that may happen here is that there are clear unknowns here. These contracts are very significant contracts, both in size, magnitude and complexity. We clearly have learned some lessons from the original CHAMPUS recapture initiative contract that was done in California and Hawaii. We have learned lessons, we have refined our approach, but the question remains have we in place the correct contract, the correct management structure?

I think one of the things that the Surgeons General were interested in was finding an opportunity to learn more lessons before we actually go through the entire process of implementing twelve separate contracts. I think that was the key issue that emerged from the video-teleconferences that will, in fact, perhaps effect what happens in the future. My sense of it was

they would like to take some time to study more in depth what is now happening in California and Hawaii and what will happen in Region VI and Region XI. I think that was one of the biggest issues that emerged from the video-teleconference.

Will that effect our RFP? Possibly. Congress has mandated that Florida be included in a contract by a certain fiscal year deadline. For us to back-off of that timeline will require congressional support. I don't know if that is going to be available, so it may not effect our RFP, but potentially there could be a "time-out" called so that people can take the time to learn the additional lessons from the operation of these contracts.

APPENDIX E

INTERVIEW WITH COLONEL STEPHEN XENAKIS

Graduate Management Project Interview

DATE: June 2, 1994

INTERVIEWER: Author

INTERVIEWEE: Colonel Stephen Xenakis, Lead Agent Project Officer, Dwight David Eisenhower Army Medical Center

Question: What do you see as the major missions, functions, and responsibilities of the Lead Agent, particularly in this region?

Answer: The mission is to write the regional health plan which consists of a collection of the local health plans of each of the MTFs in the region and from that, to write the statement-of-work for the Request-for-Proposal for the contract. Following that, the Lead Agent will go through the process in which the contract is announced, bid upon, awarded, and then finally implemented.

Question: How is the Lead Agent concept expected to integrate with President Clinton's health care reform initiatives?

Answer: It really is probably one of the first opportunities the White House has to put a footprint on what it wants its' initiatives to look like in the country because you, essentially, have an accountable health alliance regionally across the country. In turns out to be a federal alliance, but it's an alliance providing a defined benefit to a defined beneficiary population. It's the forerunner of what those reform initiatives

should look like.

Question: How were you involved in the health care delivery plans development?

Answer: I designed the process, made the requests, and gave the directives to all of the MTFs to be used and analyzed in the development of the health plan.

Question: What do you think are the key components of the health care delivery plan for this region?

Answer: The key component is that you have to know the defined population, what its' historical utilization is, what the expected utilization of services is going to be, what the cost of those services are, and project some of the changes in the health care delivery mechanisms. The plan must then be configured so that you get the most efficient and effective package.

Question: What do you think were some of the lessons learned as we developed the health care plan for this region?

Answer: The principle lesson is that there is a broad range of capabilities amongst the MTFs and a very diverse orientation between the three services.

Question: What impact do you think the recent visit to Keesler Air Force Base has had on our initiatives in this region?

Answer: It compromised our intent to design and implement a plan that we felt was more suitable to the services requirements.

Question: What impact do you think the video-teleconferences with the Surgeons General have had on our process of developing the health care plan?

Answer: They've been helpful. They have certainly facilitated coordination amongst our headquarters, MEDCOM headquarters, and the Office of the Surgeon General.

Question: What impact do you think the video-teleconferences with the Surgeons Generals have had on the Request for Proposal?

Answer: I think what we came up with, our proposal for that RFP and statement of work, was probably the optimal design for what would, in the long run, serve the needs of the services.

Question: Realizing that you were involved in Task Force Aesculapius, was there a tie in between the downsizing of the military and the development of the health care delivery plans?

Answer: Quite a bit. The process of design and reorganizing the

Army Medical Department that we conducted for the task force was done in the context of having a vision and a prediction of what the Army Medical Department was going to look like. In addition, the task force looked at what its' challenges were going to be and what it needed to do in the next five to ten years.

One very critical piece of that is how it's going to work in an environment that involves a smaller uniformed services or force; smaller but significant number of civilians, perhaps proportionally more, and a good deal more than was going to be worked in the contracting or as the Department of Defense calls it "out sourcing." The contract pillar there now is TRICARE. We clearly had to predict in the task force, as we thought about the reorganizing, what was going to be the contract capability we were going to design.

Question: Where are we now in the development process in terms of the health care plan and the Request for Proposal?

Answer: We are about to submit to Health Affairs our suggested revised Request for Proposal for Region III.

APPENDIX F

INTERVIEW WITH CAPTAIN ROBERT GOODMAN

Graduate Management Project Interview

DATE: April 18, 1994

INTERVIEWER: Author

INTERVIEWEE: Captain Robert Goodman, Executive Officer, Region III Lead Agent Project Office, Dwight David Eisenhower Army Medical Center

Question: What do you see as the major missions, functions, and responsibilities of the Lead Agent, particularly in this region?

Answer: My assessment would be that, certainly, the Lead Agents initial responsibility was, number one, to make contact with all of the hospitals in the region. Number two, was to get some sort of assessment as to what their needs were and make an assessment as to what their capabilities were. Once you get that information, then you can begin formulating how you are going to develop the regional health plan. We were the first region, obviously, that had a chance to develop its' health plan before we had to develop the RFP (Request for Proposal) and while there wasn't much time to do it, none the less, we still were the first ones to have that opportunity, us and region IV.

Once we made our assessment, then we started sending out requests for data which was called a "fact book" and then we started working with the sites on developing options. The facts and the options were combined to form a plan book, which was kind of an amalgamation of those first two which would then develop into the local health plans of each of the sites.

To stay away from being service specific, we knew from the beginning that there were clear differences on the amount of capabilities and the requirements for each of the hospitals. Some hospitals were small hospitals, primary care based that were in a catchment area that had lots of retirees. And there were others that had a lot more capability that were in catchment areas that came pretty close to having enough assets to manage effectively. There was a great diversity between the capability of each MTF and their local catchment area, and that's the truth about health care.

The Lead Agent's responsibility then was to take the local health plans and make them into a regional health plan which we did by calling in, over about a three week period, numerous people, mainly the worker-bee level folks (e.g., chiefs of coordinated care, resource management personnel), to make sure that we had what they said straight. I think that Doug (Lieutenant Crispell) did a really good job of getting that setup and got it organized and put together and we sent it out then for copying and then distribution so that they had a chance to comment.

At that same moment as it was going out for copying, the HSC (Health Services Command) central contracting folks came. I'm giving you a chronology because all these are very critical for a Lead Agent to go through and future Lead Agents, I hope, can learn from this because this is an absolute critical step. You need to get the health plan done and have the worker-bee level

people work it up, then you brief it to the commanders. And then, we immediately went into that following week in March, which was to modify the current contract, and that was a Region XI contract. But we had the health plan to do that. We knew that we needed the flexibility. We assessed the contract then by reading through it line-by-line, paragraph-by-paragraph and decided the best way to do that was to develop a matrix based on the local plans. All the key paragraphs of the contract were divided based on the MTFs and whether they wanted the contractor to do it or not. Again, a major function of the Lead Agent was to be able to coordinate making this happen. Not only Colonel Xenakis, but BG Spaulding was key in that, to include Colonel Mally at getting the right people at the right time here. This included coordination with HSC to get their folks here. It was as if nothing was working; you had all the ingredients in the soup and somebody stirred it and all of sudden it was ready. We had a lot of the pieces that were coming together and we just needed to make a few of the blocks fit and everything else just seemed to gel.

Once that happened, the future of the Lead Agent was to take it and do battle with Health Affairs. In order to circumvent them, a new tactic was tried to go through our Surgeon General and coordinate with the other Surgeon's General and you have to take your hat off to BG Spaulding for doing that. I don't see others that went that route and that was perhaps even a politically dangerous tactic to take, but he took it in order to

win support for what we are trying to do. This is what a Lead Agent is supposed to do. They are suppose to carry the banner forward even into the hail of gunfire and that has been done here.

The next thing that I envision the Lead Agent is going to do is, obviously, take back the comments and we'll have to modify the plan and I'm sure that he will take whatever guidance he is given and go the maximum extent that he can because what we want to do and Health Affairs will let us do are not the same. There is clearly a vast difference. Somewhere in between we will meet. We may not get everything we want, we may not get anything that we want, so we will have to make the best of whatever that is. Again, when that happens BG Spaulding will have to sell that to the regional commanders and if it's less than we've asked for most of the Navy sites and all of the Army sites will be very upset. But that doesn't have anything to do with BG Spaulding. He's going to have to sell them on what the new plan is going to be. Now, as the HSSA (Health Service Support Activity) commander, he does have some opportunities to start stripping assets starting 1 October 1994 and start moving assets around. Take that comment for what's it's worth, but if we lose then we need to start thinking about how he, as the HSSA commander also, is going to restructure his region. And I mean that just like I said it. We have got to be able to minimize our losses as much as possible.

Question: How is the Lead Agent concept expected to integrate with President Clinton's Health Care Reform initiatives?

Answer: Boy, I don't know what to tell you on that one. The reason is because the Army had experience in managed care and was definitely controlling its CHAMPUS growth which was the key reason we're in the mess we're in now with the one contractor. Everything we built up we stand to lose and so, this being an Army Lead Agent, the Army stands to lose a lot. With four key hospitals, one of them being a medical center, this is a big region and we stand to lose everything that we've gained during the last three years of Gateway.

The Air Force does not appear to be at all concerned with this because, once again, they are not responsible for their CHAMPUS dollars. So I think it is really going to depend Lead Agent to Lead Agent as to how they view this. Keesler clearly is not concerned with it because their medical department is not funded for this stuff and they get their O & M and military pay dollars through their MAJCOM (Major Command). It is the way that they are funded that causes a whole different paradigm of thinking that we don't experience because our medical department has all of it and we are responsible for all of it. It is an issue for us.

Question: How were you involved in the health care delivery plans development?

Answer: We started out by having big debates among the four people that we had here at the time because John McDonald was here at the time and Sue (Krell) was still here. The four of us would sit down together discuss what elements are we going to ask for. Every element was an argument, "should we include the element", yes or no. There was always points on both sides of the spectrum. Eventually we came to an understanding about what it was going to be, that we all could live with, and we published that and sent that out. That was the "Fact Book." The "options" was a similar way that we developed it. We put that together and that went out too. We did get some help by getting some of the stuff from Region XI. They sent us some of the things that they did and that kind of answered some of the member's questions about whether we were putting something together that had been done before or not. Eventually it got put together and it went out.

I think that one of the things that was very beneficial in this region was that we made "site visits" and each of us had four, five, or six sites that we would visit. It was important because we would talk to the commanders and they were able to say how good or bad it was and whether or not they agreed with the whole concept. It gave them a chance and it was very important to build the spirit that BG Spaulding was looking for, to go out there and visit them and let them show their facility off. And that was helpful.

Question: What do you see as the key components of the health care delivery plan?

Answer: If we get it the way that we originally asked for it and Health Affairs buys off on it, then the key aspect will be the matrix and what they (MTF commanders) want the contractor to do and what they want to do themselves. This is the best incentive that I know of because it's a capitation-based model to get the MTF to move into its most efficient organization and that's to downsize its inpatient capability to the extent that they possibly can. A lot of them have a lot of filled beds, particularly in the Air Force and the Navy, because they are still funded differently than we are. Workload is being done for the sake of workload to get money and once that goes away then there's clearly a lot less need for beds. Even here at Eisenhower we used to have 360 filled beds; now we have 210. We are doing less work now. We're probably only doing what should have been done in the first place.

This is just the nature of the beast, capitation. You change your way of doing business and this would allow them to move into that. They can beef-up their outpatient capability which a lot of the Air Force hospitals could use that, certainly. If we don't go into the most efficient organization the contractor will put us there. That's what's going to happen in Region VI and that will be what happens here in IV and III. Once they start, in order to prevent the bid-price-adjustments, the

contractor will be dictating how many visits we see and who we see and this is the real risk that we run. If we want to run our own show then this is bad. If we don't want to run our own show, then this isn't bad. It almost depends on your perspective. Once again, depending on what service, some services say this is okay, we don't. They're going to move into the most efficient organization because they will have to. That's the way it's going to be. I don't see what we can really do much different. We have to reorganize and do whatever we can. You just can't quit fighting, but you do what you can do. One thing we can do and take an active role in, and we would do this either way, would be promote getting into your most efficient organization, number one. Number two would be redoing the air evac routes because they are in desperate need of doing it. On one route the flight starts at Eisenhower and goes to Benning and around the region and then on the way back it goes in the opposite direction to Keesler and this doesn't make for any good flow of patients. This doesn't help us be as efficient as we can, in fact, it impedes it. Either we need to restructure the air evac routes or find a separate program that puts people on civilian airlines to get them to Eisenhower because we've got to get the referrals in. If the air evac system can't do it then we don't need it. We need to get a new system that will do it. It has to work for the military and not for the Air Force air evac system and we're talking about the transport of patients here and we need to become as efficient as we can. Something has to be done there.

Question: What do you think were some of the lessons learned as you developed the health care plan for this region?

Answer: We at Eisenhower made a key mistake when we, essentially, put only one resource into the Lead Agent cell prior to November. And that person went at it alone for almost two and a half months before 1 January. We were so far behind the power curve at that time that we really were way behind everyone else. I can see now, and I think Colonel Xenakis had everything to do with this, that we have moved way ahead of all of the other regions, but it certainly wasn't fun getting there.

The biggest lesson learned was get started and get started now. We were so far behind that we were trying to deal with just basic questions when everyone else was expecting us to be sending out guidance because every other Lead Agent that was in the game right now had already done that. The worst part of the whole thing that we've gone through was the month of January where we didn't know which way was up or down.

Question: What impact do you think the recent visit to Keesler Air Force Base will have on our initiatives in this region?

Answer: It had the effect that it showed the stark difference between Region IV and Region III. Region IV was perceived by just about everyone as being way ahead of us and they hadn't even read the contract. They didn't even know what was in the

contract. Taking that for what its worth, it just showed the stark difference between Region IV and Region III and it showed the political realities of what we were dealing with. They were committed to TRICARE no matter what and all they had to do was just check the block that they had, in fact, finished a health plan because they were going to accept TRICARE contract as written. That's still a position they hold. The modification of the contract was just spending two days there, shaking hands and walking away because that's literally what was going to happen. They were going to accept TRICARE because that was their mission. I think that "utter shock" may have been the best way to describe how they viewed Colonel Xenakis' direct questions on issues of contracting because they had not read the contract. I'm not sure if it put up fences at the time, but fences were built, none the less. They did send some people that following week to mark up the contract. And one of them was just shocked that we were making changes as drastic as we were. The other one's consistent comment was "this is CAM all over again." This is what we have tried to stay away from, but those were his feelings and his assessment of what we were trying to do. So when he went back I'm sure there were numerous discussions about what we were trying to do, and obviously there was clearly not agreement with what we were trying to do which is why they have taken the position they have taken.

Question: What impact do you think that the video-teleconference with the Surgeons General have had on our process of developing the health care plan?

Answer: They've had the effect of requiring us to look at the health plan again to decide if it is going to meet what we need it to meet. We decided that, in fact, we need to restructure how the health plan is set-up so that it matches the matrix which matches the contract. Clearly, we were educating more than anything else because so many of them had not read the contract. The people that had not read our health plan, particularly at Health Affairs, said "boy, this sounds like CAM." The ones that did read it said that it wasn't within the spirit of TRICARE because the military was trying to control their own destiny. We obviously have some problems with what we are trying to sell because we stand the most to lose.

APPENDIX G

CHRONOLOGY OF SIGNIFICANT EVENTS

Regional Health Services Plan Development Process

Chronology of Significant Events.

DATE	EVENT
	Initial Planning
Oct - Dec 1993	The Coordinated Care Division, EAMC, began the process of setting up meetings with regional commanders to discuss the goals/objectives for developing the Region III health plan. Planning efforts were primarily conducted by the Chief, Coordinated Care Division (CCD) and his divisional administrator. The division received numerous questions from local MTFs concerning the regional direction and MTF plans. At a workshop held by the division for regional MTF coordinated care personnel, MTFs indicated that they wanted more structure. The EAMC Coordinated Care Division asked their MTF counterparts to begin to "define" their catchment areas (i.e., number of eligible beneficiaries, services available at MTF, referral patterns) to assist in capturing a snapshot of the region.
3 Jan 1994	Colonel Xenakis, the Region III Lead Agent Project Officer, held his first formal meeting with his staff and representatives from the CCD and EAMC command element. His staff consisted of an Army and Navy officer, and a civilian systems analyst. The purpose of the meeting was to establish timelines for the completion of the health services plan for Region III. Colonel Xenakis stated that EAMC would be working with MTF Commanders with a very customer oriented focus and that MTFs perceived EAMC as supporting their own self-image. It was decided that someone from the Lead Agent office or CCD would visit each MTF in the region. The intent of the visits was to gain an understanding of what each MTF was doing and to formulate a strategy to develop the regional health plan.
	Individual MTF Plan Formulation
Jan - Feb 1994	The Lead Agent Office began sending out requests for catchment area specific data to each regional MTF. This was designed to

gather specific facts about the medical resources/capabilities in the region. The facts aided in the development of the types of services the MTF could provide in-house and those that required outside assistance. The facts and options where combined to form a "plan book" , resulting in individual plans for each regional MTF. The individual plans were designed to allow MTF Commanders the maximum amount of flexibility, enabling them to select the functions that should be done by the MTF and the contractor. The amalgamation of individual MTF plans resulted in the formulation of the Regional Health Services Plan.

Regional Plan Formulation

Feb - Mar 1994 — Once the local plans were devised, the Lead Agent Office developed a regional plan using regional personnel. Over a three week period, many of the key developers of the local plans (e.g., Chiefs of Coordinated Care Divisions, resource management personnel) came to EAMC and working in teams of 2 to 4 personnel, developed certain sections of the regional plan. This collective effort was accomplished to ensure that the regional plan reflected local MTF Commander's desires and capabilities. There were numerous debates on the CHAMPUS funding streams, the availability of establishing partnerships, the sharing of resources within the region, etc.. The Lead Agent office constantly sought clarification from Health Affairs on issues that were unclear.

9 Mar 1994 — Following the initial draft completion of the regional plan, a "murder board" was held with representatives from HSC's Coordinated Care Division and the Region III health plan developers. The "board" provided a forum whereby the local plan developers could articulate the goals and objectives of their plans and receive direct feedback from HSC. In addition, it allowed for clarification of some unclear issues that were unresolved to that point.

11 Mar 1994 — The EAMC Commander, DCA, and key personnel in the Lead Agent office, traveled to DoD Region IV Lead Agent Office, Keesler Air Force Base, Mississippi. The purpose of the visit

was to gain a greater appreciation and understanding of the differences, capabilities, and projected contractor roles in each region.

18 Mar 1994 — Personnel from the HSC Contracting Office arrived at EAMC and began modifying the Region XI contract to reflect the requirements of Region III. The modification came as a result of a line-by-line, paragraph-by-paragraph assessment of the key components of the Region XI contract and Region III's desires. This correlation of regions resulted in a Region III specific contract based on the health service plans developed by the local MTF Commanders.

6 Apr 1994 — A video teleconferences was held with the Army, Navy, and Air Force Surgeons General, MEDCOM, and the Lead Agents from Regions III and IV. The video teleconference was an attempt to orient the decision makers to the process of developing the health services plans, and the points of contention between the regional contracts. The Region IV plan was similar to the plan adopted by Region VI. The Region III plan was a more flexible giving the Lead Agent greater input into where the contractor will provide services. There was significant debate over the ability of the Lead Agent to write specific contractor requirements into the RFP (i.e., where the contractor will or will not provide services). A major obstacle that required resolution was the fact that Health Affairs did not want the Lead Agent to specify contractor requirements.

14 Apr 1994 — A follow-on video teleconference was held with the same attendees as the 6 April meeting and the Lead Agent from Region VI. The purpose was to discuss the differences and similarities between the regional plans. After discussion of each region's health care plan, the Surgeons General decided to proceed incrementally with the level of flexibility that Region III desired. The area of concern that the Surgeons General stated they needed to discuss further involved the allocation of CHAMPUS funds (i.e., retained by services, allocated to Lead Agents).

19 Apr 1994	Admiral Martin, DOD Health Affairs, met with the flag-level representatives of Regions III and IV to review and make decisions on specific written proposals for changes to the requirements in both regions. Admiral Martin approved the Region IV RFP, but disapproved the RFP for Region III because it was inconsistent in several significant ways with the policy guidelines established for the TRICARE Program.
May - June 1994	<u>Regional Plan Modification and Completion</u> Based on the guidance provided by Health Affairs, the Lead Agent office modified the existing Health Services Plan and RFP to more closely align, in format and function, with those of Regions IV and VI. The intent of Health Affairs was to ensure that TRICARE looked the same in every region. Specifically, the Lead Agent was directed to eliminate many of the options or functions that the local MTFs had initially stated they would perform in their facilities. In addition, due to the size of the Region III Plan, it would not be included as an attachment to the RFP as originally planned. Instead, the Lead Agent office developed a more condensed version of the Plan, entitled Attachment 28, that would accompany the RFP.